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ABSTRACT

This newsletter issue highlights a variety of successful youth, family, and community program models that have been developed to curb substance abuse, lessen risk factors, and strengthen protective and supportive resources for individuals and their communities. The newsletter includes the following articles: (1) "A Systems Approach to the Prevention of Alcohol and other Drug Problems"; (2) "Integrating Parent Support into Residential Treatment Programs"; (3) "Ethnic Diversity and the Involvement of Parents in Preventing Adolescent Substance Abuse"; (4) "Empowering Parents to Prevent Drug Abuse in Public Housing"; (5) "Community Partnerships for Alcohol and Other Drug Abuse Prevention"; (6) "Families and Schools Together (FAST): A Prevention Program that Works"; (7) "American Indian Families Build New Strengths on Ancient Traditions"; (8) "Parenting as Risk-Focused Prevention"; (9) "Family Involvement is Key to Successful Worksite Treatment and Prevention Programs"; (10) "DASA: A Model for Community Substance Abuse Prevention"; and (11) "Useful Evaluation for Community-Based Prevention Programs." In addition, the newsletter includes reviews of films and videos on substance abuse and prevention, and a resource file on prevention programs, publications, and organizations. (HTH)

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FAMILY RESOURCE COALITION

# Report

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SPECIAL FOCUS

# Strengthening Youth and Family Resistance to Alcohol and Other Drug Abuse

DASA: Illinois Department of Alcoholism and Substance Abuse

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■ by Donald G. Unger, Guest Editor

Among the world's industrialized nations, the United States ranks with the highest for alcohol and other drug abuse.[1] Almost one-fifth of young, first-time mothers are using alcohol and/or marijuana during pregnancy, and estimates are that as many as 375,000 infants are born drug-exposed each year.[2,3] One-fourth of America's youth report having used one or more illicit drugs in their lives. More young adults—18 to 25 years old—become heavy drinkers and use crack than any other age group.[4] Youth who abuse drugs are more likely to experience addiction, poor school performance, unprotected sex, disruption in family relationships, job instability, drunk driving, public confinement, and more physical problems than youth not using alcohol and other drugs.[5]

The availability and use of illegal drugs in the United States has created devastating problems for children and families, making it imperative that parents and professionals become actively involved in the prevention of substance abuse.

In order to encourage that involvement, this special focus issue of the *FRC Report* highlights a variety of successful youth, family, and community program models that have been developed to curb substance abuse, lessen risk factors, and strengthen protective and supportive resources for individuals and their communities.

**Youth programs.** The majority of substance abuse prevention programs have focused primarily upon youth.[6] "Affective enhancement" was one early strategy aimed at improving general intrapersonal and social growth. Other early models included: (a) alternatives programs, providing community activities and remedial skills; and (b) a knowledge or informational approach, increasing youth's knowledge of drugs and the consequences of abuse. Unfortunately, these efforts have had little success in preventing substance abuse behaviors. Research has consistently shown that the affective, alternative, and informational approaches *alone* are not effective in preventing substance use among adolescents.[6]

Recently, two psychosocial approaches have yielded much more promising

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results. The first group of programs places great importance on peer influences, recognizing that peer group membership supports drug use and that drug use initiation is a social decision and social event. Consequently, the curriculum emphasizes resistance/refusal skills and social skills.

The second group of programs views substance abuse as a socially learned behavior involving modeling, reinforcement, and beliefs. Through personal and social skills training, youth learn effective decision-making, anxiety reduction skills, social and interpersonal competence skills, and they develop a healthy sense of self-efficacy and personal responsibility. Peer leaders are often used to help convey the curriculum to other youth. Programs such as the Life Skills Training[7] program, which focuses primary attention on the development of personal and social competencies in early adolescence, have had the most promising published results to date.[8]

**Parent and family education programs.** Only recently have families been included as an integral part of substance abuse prevention interventions. The most common approach is parent education, often incorporated as a component of a youth, school-based prevention program. The focus is on the parent-child communication, consistency in discipline and types of discipline, praise and reinforcement, positive involvement with youth, poor or inconsistent parental modeling in regard to smoking and alcohol use, and parental monitoring/supervision.[9] Programs use such parenting materials as the *Families InTouch* series and the *Talking with Your Kids About Alcohol* curriculum which are specifically designed to prevent substance abuse (see Resource File).

Some programs involve the whole family in skills training. In Families and Schools Together (described on page 10), for example, parents and their children participate in weekly multi-family meetings followed by monthly meetings for graduate families. The program works cooperatively with local schools and community agencies.

**Parent treatment programs.** Treatment programs for parents who are users are an important component of prevention services. Substance abusing parents place their children at risk for many problems such as substance abuse, child abuse and neglect, and behavior and developmental disorders. Assisting these parents can prevent relapse and further problems for their children and families. However, as Harvey and Comfort point out (see page 4), treatment services rarely take the patient's needs as a parent and family member into account. As a result, support systems for parents in recovery have been inadequately developed.

**Community-based family interventions.** Family resource and support models focus on empowering families in the context of their communities.[10,11] They work with natural support systems such as churches and extended families, local institutions such as schools and community centers, and adapt their approaches to fit with a community's ethnicity/culture.

Family resource programs, which developed out of concern for the welfare of families with young children, are now adapting their services to help families with older children who are at risk for substance abuse. Unfortunately, there has been little research on what types of family resource approaches are most effective in preventing substance abuse. Suggestions for meeting the challenge of conducting useful evaluations and providing this necessary information are discussed in this issue (on page 18) and elsewhere.[12]

To support the work of family resource programs and other prevention efforts, community coalition building is being used to foster a sense of collaboration and responsibility among parents, schools, religious and voluntary organizations, and other community and private institutions (see page 8). Community organizing efforts have worked with private sector human resource departments, partnerships have been developed between schools and community-action groups, programs have been implemented to teach teachers how to intervene in student substance problems, and parents have been directly involved in drug prevention efforts by becoming peer trainers. Still other community-wide programs have used the mass media and public service announcements to educate people about AIDS and drug use behaviors, and the consequences of drug use during pregnancy.

**New directions for empowering families.** Comprehensive, multi-level, preventive interventions that include school, family, and community components hold the most promise for success. Programs that involve multiple settings can provide young people and their families with consistent messages about substance abuse in many areas of their lives. Comprehensive programs can also focus on drug abuse in the context of other child and family problems, since drug use is typically part of a constellation of problem behaviors. Programs that rely on only one approach to reducing drug use have demonstrated limited effectiveness.[6] Families Matter! (see page 15) is one example of a comprehensive program for youth and their families.

Some of the exciting and important challenges that lie ahead for family resource professionals involved in substance abuse prevention include: (a) designing programs that effectively reach minority, low-income, and ethnic families (several successful models are presented in this issue); (b) identifying components of family resource programs that contribute to the prevention of substance abuse; (c) combining family resource principles and programs with currently existing, narrowly focused youth substance abuse prevention and treatment programs; and (d) developing innovative ways to recruit, involve, and sustain parent participation in substance abuse prevention programs. As shown by the programs in this *FRC Report*, family resource programs are one very important, essential part of the solution for preventing alcohol and other drug abuse. □

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■ by Darlind J. Davis

# A Systems Approach to the Prevention of Alcohol and Other Drug Problems

When the history of America is written, the twentieth century will no doubt be portrayed as the era of alcohol and other drug problems. In the complex nature of addiction, the most problematic issues surround its impact on America's families. The use of alcohol and other drugs by pregnant and postpartum women poses some of the most far-reaching of all social, medical, psychological, and philosophical issues confronting our nation today. Young children are affected by alcohol and other drugs as never before.

In the 1970s and 1980s, many federal efforts concentrated on the development of new strategies for preventing alcohol and other drug use, and national parent organizations led an aggressive campaign to pass legislation for meaningful action by government. The establishment of the Office for Substance Abuse Prevention (OSAP) within the Department of Health and Human Services in 1986 began a serious, sustained effort to plan effective programs with the promise of countering the dramatic spread of alcohol and other drug abuse among children and families.

OSAP supports the development of new materials and training programs that focus on systems—both in the family and its total environment—through OSAP publications, grant programs, and workshops. Recent research suggests that family influences are the most powerful factors in determining the use or non-using behavior of youth. To promote parental involvement in all programs for children and youth, our mission is to cross the generational boundaries by recruiting not only the young people but the whole family as well. Strengthening the family can be accomplished through direct services as well as improved service systems.

OSAP recognizes that multiple, comprehensive strategies, woven into a strong systems approach, produces the greatest likelihood for success. Using research results from the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, and the National Institute on Mental Health, OSAP tests out new model programs and provides in-depth information on the target audiences and age groups involved in service demonstration projects. Programs aimed at the family, young children, and community mentors make up components of the systems approach to prevention.

Several exciting programs are in the process of implementation and piloting: ***Parent Training is Prevention*** is a monograph designed to impart skills, knowledge, and activities for parents and significant adults in the lives of children. Ideas on cultural competency, accessing hard to reach parents, and appropriate roles for parents in prevention as well as many resources for further study are provided. Almost 200 pages of expert opinion and practitioner savvy are presented. OSAP is finalizing a videotape to accompany this manual; it can be obtained free of charge from the National Clearinghouse for Alcohol and Drug Information (telephone 1-800-SAY-NO-TO).

> ***"...prevention programs that emphasize the family, lessen the risk factors, recognize the role of culture, focus on all substances including alcohol, and overlay with a community empowerment strategy will be the most successful."***

Through a contract with the National Head Start Association, OSAP funded the development of training manuals for parents, teachers, and children. Called ***Parents and Children Getting a Head Start Against Drugs,*** by Dr. Ura Jean Oyemade, these manuals are in the pilot stage and will be available in early 1992. The curriculum is designed to provide needed, basic information to parents and teachers. A discussion of risk factors frames the ten session manuals which are accompanied by activity sessions. African-American and Hispanic Head Start children are the focus of this publication series.

***Babes and Puppets Helping Children: Myth Mary and Early Bird Teach Prevention,*** by S. Abbott, is another special project funded by OSAP in an effort to reach high-risk children through unique methods. Seven puppet characters discuss difficult topics and enable children to express their fears and impressions in a safe and developmental format. Though the *Babes* program has been available for many years, this special project looked at the use of the puppet technique with grandparents and older persons living with young children as caretakers and family support/significant others. *Babes* has received wide acceptance in Native American communities with young children.

One of OSAP's newest yet largest programs utilizes the methods of individual change models in a community-based systems approach called the **Community Partnership Demonstration Program** (see page 8).

OSAP believes that reducing risk factors is a method of addressing individual conditions and behaviors. Special attention must be given to early childhood—particularly the first year of life—and caretakers, siblings, and positive peer groups. Cultural diversity requires the use of culturally appropriate methodologies; such models can achieve much in the area of consciousness, confidence, competence, and character. In short, prevention programs that emphasize the family, lessen risk factors, recognize the role of culture, focus on all substances including alcohol, and overlay with a community empowerment strategy will be the most successful.

OSAP welcomes your ideas and creative approaches to the prevention of alcohol and other drug abuse. Please share with us and participate in our National Training System, grant programs, and information centers. For further information on the National Clearinghouse for Alcohol and Drug Information (NCADI), call 1-800-SAY-NO-TO or write to OSAP at P.O. Box 2345, Rockville, MD 20852. OSAP has many documents and materials to assist you in planning systems approaches and wishes to hear from you today! □

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■ by Cathie Harvey and Marilee Comfort with Nancy Johns

# Integrating Parent Support into Residential Treatment Programs

Don't talk about what you want to do for your baby. If your baby died tomorrow would you still have a reason to stay off drugs? Who are you living for?

*—Detoxification program staff member during a group therapy session*

What skills do certified addiction counselors and case managers need in order to provide ongoing support and education for recovering parents of young children? Is the process of confronting addiction compatible with the process of nurturing nurturers? Are men and women in drug and alcohol treatment (D/A) programs interested in support and education for their role as parents of young children?

These are just a few of the questions Philadelphia Parenting Associates (PPA) raised in response to a 1988 request for consultation from the city's Diagnostic and Rehabilitation Center. The DRC had received a community demonstration grant from the National Institute on Alcoholism and Alcohol Abuse to establish Hutchinson Place (HP), one of the region's first residential treatment facilities for homeless, drug-dependent women and their young children. Knowing about PPA's success in helping traditional shelters for homeless families become more family-centered, the Hutchinson Place staff wanted PPA to work with them, their administrators, and parents to define issues and develop strategies for integrating support and education for parents into all aspects of the program.

Posing many questions about whether or not drug and alcohol treatment programs were an appropriate area for collaboration, PPA staff began studying principles of addiction counseling with the DRC staff. Next, ongoing communication was established with the Hutchinson Place administrative team regarding staff and resident needs and program policies and practices. This preliminary process of information gathering was essential for tailoring parent support and education to the requirements of the D/A staff and the recovering women. Finally, PPA provided inservice training for staff members and workshops for the mothers. The overall focus, for each level of planning and training, was on integrating parent support and education into the routine treatment program.

Since beginning this work with Hutchinson Place, PPA has established collaborative relationships with several other D/A treatment programs and drug-free shelters. Our experience with each program confirms that parent support and education *is* an essential element in the recovery process. It has shown that staff effectiveness *is* improved through training in child development and techniques of parent support. And, that parent support and education *can* be integrated into routine D/A program activities. This article draws upon PPA's ongoing relationship with Hutchinson Place to describe some of the issues encountered and some of the strategies currently in use by PPA.

## Consultation on Policies and Practices

Historically, residential D/A treatment regimens have been designed *by* adult men *for* adult men. They involve confrontation, strict routine, and a full schedule of meditation as well as group and individual therapy sessions. The treatment emphasizes individual responsibility while encouraging the surrender of individual needs to the recovery process. Participants are required to focus tremendous energy on themselves.

Given this intense focus on the individual, the administrative guidelines in D/A programs tend to ignore normal parenting needs. A simple example is the use of curtains instead of doors at the entries to family sleeping areas at Hutchinson Place. The curtains allow for surveillance of the women, but make it very difficult for mothers to monitor their children during sleep and quiet times. PPA suggested that child gates be supplied to families in order to prevent toddlers from wandering off while parents sleep. But gates are an expense that must compete with other expenditures in the treatment program. Such competing priorities have required that PPA staff be persistent and specific in explaining that gates are an important way for parents to establish a safe environment for their children. The mastery of such childcare tasks is as important to recovery as success in maternal psychosocial areas.

## Consultation and Training with Staff Members

A child development knowledge survey circulated among Hutchinson Place staff indicated that they had a reasonable understanding of developmental milestones and age-appropriate behavior. However, it documented a tremendous diversity of opinion about childcare practices such as feeding, weaning, and toilet training. These findings at HP have been confirmed through PPA's experience in all other D/A programs.

D/A staff are usually trained in the course of addiction. Frequently, they are in the advanced stages of their own recovery and have important intuitive skills for supporting the process of recovery and bring a strong personal commitment to their work.

Although residential program staff generally accept the fact that they are responsible for parent *and* child, their focus is usually on the adult. Many D/A staff members report having had difficulties with their parents during childhood as well as serious problems in parenting their own children. Others reported only minimal involvement with the rearing of their children. PPA found that prior to our training sessions in principles of parent support, D/A staff members defined childcare in terms of physical maintenance and discipline, with little or no appreciation for play as a way for parents and children to build relationships and learn social and language skills. Staff members knew only a few songs to sing with children, did not see any value in reading stories with children, and identified corporal punishment as the most effective technique for discipline—even though corporal punishment is not permitted in most residential programs!

Initially D/A staff reacted to in-service training sessions on parent support and education with a mix of skepticism, curiosity, and apprehension. Therefore, our current sessions explore staff members' intuitive competencies and encourage them to draw on the best in their personal parenting histories. Every session is experiential rather than didactic. Basic infor-

mation about child development and child management is blended with problem-solving around common concerns. Judgmental attitudes about parent/child relationships (e.g., parents who don't take a pacifier away from a 3-year old are "lazy"); conflicts between D/A staff members' values and program norms (e.g., corporal punishment); or, erroneous information about child development (e.g., potty training at six months) can only be challenged after considerable trust is established and staff members begin to feel confident in some areas of parent support.

In addition to group training sessions on parent support, PPA staff also facilitate case conferences to discuss individual parenting situations. These sessions allow for additional informal education and result in action plans that involve the whole staff—working as a team and using a comprehensive, supportive approach.

A basic paradigm shift is usually required before a staff member can see parent support as an integral part of his/her work with the women. When this shift occurs, however, they begin to observe parent-child interaction more sensitively, to nurture the women as mothers, to provide anticipatory guidance around parent/child and child development issues, to model appropriate behavior with the children, to sit with mothers and review problematic parenting situations, and to use teachable moments with parents.

### "I Want to Do Right by This Baby."

*—A resident states the need for parenting support among mothers in recovery.*

As part of the evaluation plan for Hutchinson Place, videos were made of each woman playing with one of her children. Under the controlled circumstances of a playroom—with only one child and a variety of age-appropriate toys—the women were generally responsive to child-initiated activity, played actively, and handled their children gently. Yet daily life in HP was characterized by children who were unattended, by parents shouting commands across the dining hall to children, and by frequent examples of parents' inappropriate expectations for their toddlers and preschoolers.

From information gained through the videotapes, informal observations, and parent workshops, it was evident that each mother showed real needs for parenting support and education—from simply increasing her repertoire of age-appropriate activities to developing bonds with her newborn.

For all of the women, however, those normal needs were complicated by their stages of recovery. Women in the early stage of the recovery process were often fatigued, had difficulty concentrating, were malnourished, and depressed. But, as some of their physical stamina returned, the women began to come to terms with their sense of guilt regarding their children—often establishing unrealistic standards for themselves as parents. As they proceeded in therapy after detoxification, they started to work on issues of self-control, managing feelings of anger, and establishing routines for daily living. Ironically, these were the same issues they needed to address with their toddlers and preschoolers, further complicating the challenges they faced as mothers and as functioning individuals.

### Workshops with Mothers in Recovery

In order to address this variety of needs, PPA has found that weekly workshops are optimal, minimally offered in a six- or eight-week series. The best size for workshops in D/A programs is eight or fewer women, and the recommended length is one hour or less. Realistic objectives for parent workshops are to create opportunities for the women to have positive experiences with their children, to practice child care skills, and to create an environment in which the mothers can safely raise questions and share concerns about their role as parents.

In facilitating the parent workshops, PPA employs a variety of techniques that encourage the mothers to discover and exercise their power as parents. Exercises are intentionally structured to build on the system of mutual support that exists within the facility. And, each group establishes a set of ground rules for managing manipulative behavior, intense feelings carried over from other parts of the treatment program, and difficulties between individual mothers.

PPA's workshops in D/A programs are a blend of discussion and problem-solving sessions, parent activities, and parent/child activities. Discussions and problem-solving focus around issues such as sexual development in children and parent/child communication. PPA elicits concerns from the parents, uses those concerns as a framework for weaving in critical information about child development and child care, and then organizes the enlarged concerns into areas for discussion. PPA selects activities for parents and parent/child activities with three criteria in mind: the activities must promote physical contact between mother and child, encourage mothers to observe and interact with their children, and be fun! Infant massage, making and using playdough, making finger snacks, and making simple toys are popular activities with the mothers and meet the criteria.

PPA's experience at Hutchinson Place and five other residential D/A treatment programs has shown both the need and the potential for the programs to become more family-centered. Some of the next steps include securing more stable funding for collaboration between family support programs and D/A programs; interesting the research community in describing and documenting the critical paradigm shifts that allow D/A staff to become more family-centered in their practice; and defining options for disseminating successful strategies for work in D/A programs. □

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by Katherine Chun and Bart Aoki

# Ethnic Diversity and the Involvement of Parents in Preventing Adolescent Substance Abuse

In recent years, as broader cultural diversity has developed in communities across the country, programs for parents and families have recognized the need to tailor their services more specifically. Since 1987, the Asian Youth Substance Abuse Project (AYSAP) in San Francisco has been formalizing an approach to prevent substance abuse among high-risk adolescents from six different Asian ethnic groups. Funding from the Office for Substance Abuse Prevention (OSAP) has enabled the project to focus its plans for parent involvement to the cultural needs of each group—while making significant progress toward the goal of reducing substance abuse among the most vulnerable teens and families.

AYSAP is a joint effort of seven Asian youth serving and drug treatment agencies —Asian American Recovery Services, Bill Pone Memorial Unit of the Haight-Ashbury Free Medical Clinic, Chinatown Youth Center, Japanese Community Youth Center, Korean Community Services Center, Vietnamese Community Youth Development Center, and West Bay Filipino Multi-service Corp.—that together serve over 8,000 at-risk youths annually. In the late 1970s, San Francisco service providers began seeing large numbers of Asian youth involved in alcohol and drug use. An Asian American Substance Abuse Task Force was formed in 1983 which included representatives from 25 different Asian youth and family-related organizations and agencies. The efforts of the original task force and its successor organizations form the basis for AYSAP's continuing broad support.

Beginning with an understanding of the primary role of the family in all Asian cultures and the awareness that these ethnic communities differ along significant dimensions, AYSAP's approach with families is coordinated and specific. The project's consortium structure ensures that all services are planned and implemented by personnel and agencies who are credible and trusted members of the specific community. Without this critical organizational framework as a basis, many of AYSAP's programs may not have had their acknowledged success in involving the key family members of high-risk Asian adolescents.

The development of AYSAP's strategies for involving parents in preventing adolescent substance abuse began with identifying the risk factors relevant to high-risk Asian youth and their families. Importantly, AYSAP experience revealed that specific cultural issues often change the nature of each risk factor. For example, one of the issues complicating prevention efforts for Asian families is the extreme shame surrounding substance abuse and their reluctance to seek help outside of the family. As a result, a number of innovative family strategies have been developed within AYSAP prevention programs that minimize shame by reinforcing cultural strengths, validating the need and importance of both American and Asian culture, and linking prevention efforts to the family's natural support system. Intergenerational conflict between parents and children is another critical risk factor. To assist families in resolving these situations, AYSAP bilingual and bicultural staff involve parents and teens in both skill development programs and experiential activities.

The following are examples of ethnic-specific family strategies developed in the AYSAP project:

**The Chinese component** involves parents and teens in organizing biannual Family Forums where the staff facilitates groups to create humorous and educational skits based on the immigrant experience and family conflicts. Parents and teens form teams to play a family game in which they answer specific questions related to the skit and give examples of what they would do in a particular family member's situation; the audience members decide which team gives the best answer. Such use of dramatizations form a basis for addressing intergenerational conflicts in a manner that minimizes direct blaming and overpersonalization of issues.

On the other hand, **the Japanese component** has adopted a mediation approach to intergenerational conflict that avoids violating the Asian hierarchical relationship and therefore minimizes the loss of face. As with traditional intermediaries, such as a respected uncle or cousin, AYSAP staff assume intermediary roles in order to manage conflicts between parents and teens.

**The Filipino component** targets a majority of families who are Roman Catholic and part of a large religious community. The staff involves parents through links with clergy in the community; priests are recruited as partners in developing drug prevention presentations, parenting skills workshops, clean and sober religious celebrations, and family dances. For many Filipinos, the church is the most natural place to discuss personal problems. Self-disclosure in this spiritual setting often counters the shame and stigma associated with revealing family problems and substance abuse.

Working with a large population of immigrant families, **the Vietnamese and Korean components** focus their primary intervention on helping families cope and adapt to the many changes that impact upon their family relationships. The bilingual and bicultural staff acts as the parent's broker to the new culture by providing orientation to schools, community services, and vocational resources. Using strategies that are non-blaming and preventive in focus, the staff builds trust and acceptance by conducting home visits and encouraging parents and their children to organize activities during cultural festivals. In this way, parents are helped to see themselves as cultural experts who have the power to enrich their children's bicultural heritage.

AYSAP family approaches vary according to the specific Asian ethnic community, but all strive to develop new skills and resources that enable families to bridge intergenerational and cultural gaps. The program aims to support a sense of family in culturally comfortable terms and to develop mutual respect and understanding between parents and their children.

Resources developed by AYSAP to help Asian families include a Chinese parenting guide entitled "Ten Principles of Raising Chinese American Teens" by Dr. Evelyn Lee (1988). This parenting workbook has been translated to Vietnamese with ethnic adaptations (1991). Other resources include a drug education/information booklet for parents written in Japanese (1989) and Korean (1990).

AYSAP health educators provide in-service trainings and technical assistance to other providers on culturally responsive family strategies that have worked successfully in their ethnic communities. □

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# Empowering Parents to Prevent Drug Abuse in Public Housing

■ by Paula C. Kemp

In the late 1970s, middle-income Americans arose to meet the threat of spiraling drug usage through thousands of parent groups formed in furious reaction to the marketing of mind-altering drugs and paraphernalia to children. The first of these grassroots groups, an organization that became National Families in Action (NFIA), started in 1977 in Atlanta, Georgia. NFIA collected accurate information to educate parents, helped other groups form that would empower parents to encourage their children to avoid drugs, and influenced policymakers to support a drug-free lifestyle.

The parent groups were successful in shining a spotlight of attention on drug use, in helping parents find support among their peers, and in pointing out how important their educated opinions were to their own children. Drug use, which peaked in 1978, began to decline steadily as parents became aware of the harmful effects of drugs.

This was not the case in poor and depressed inner-city communities, however, where the abuse of crack was spreading wildly. National Families in Action, theorizing that *all* parents want what's best for their children, conceived a plan to replicate the effective work of upper- and middle-income parent groups among families who lived in public housing. Socially conscious groups were already at work in this area, but most targeted youth directly—inadvertently bypassing parents. NFIA felt this approach reinforced the parents' feeling that they were powerless to influence their children and ignored the sad fact that so many of the parents in public housing were children themselves.

Early in 1990, we obtained a five-year grant from the Office for Substance Abuse Prevention to create Inner-City Families in Action and to establish a presence in Bankhead Courts, a public-housing community with a tough reputation and located in an isolated area of Atlanta.

The community had few trees, no flowers, and little grass. All families living in Bankhead Courts were black. Nearly all households were headed by women, and most were welfare recipients. Despite this bleak picture, many concerned and caring parents tried to provide a safe and healthy environment for their children, but they felt alone and frustrated.

Working with CASCADE, a drug-prevention group involved in middle-income black communities, we slowly earned the residents' trust. In an apartment loaned to us by the Atlanta Housing Authority, we cooked and ate side by side with residents. We listened as they talked about the community's strengths and weaknesses. We surveyed their children about drug-related activities and walked door to door, polling the residents about their perception of drugs, safety, and needs.

The residents knew we were there to help them become drug-prevention leaders but told us—in no uncertain terms—that they first needed summer jobs for their children and nearby jobs for adults. A Jobs Committee was formed and we obtained employment for many youngsters through the Private Industry Council. Attempts to generate local jobs for adults were much less successful, but our focus on their needs won the cooperation of several key leaders.

Our first drug-education class included sharing the results of the youth survey with the parents. They were not surprised to find few youths using drugs. They were, however, amazed to hear that the children admired their mothers and fathers and other family members. Showing parents that they were more important to their children than professional athletes and rap or rock stars proved to be the incentive they needed to attend the drug-education classes.

The curriculum, "You have the Right to Know," developed by National Families in Action (see Resource File), is culturally specific and focuses on the disproportionate toll that drug abuse takes on African-Americans. The material examines the effects of various drugs on the body and especially on the brain. We found that these parents were well aware of the effects of drugs on behavior, but didn't understand what happens to the brain to cause the behavior. They were starved for information and became our ambassadors to the community.

By the third class, participants were crowded into two rooms of our apartment and sitting on the stairs. Using a collaborative learning technique, class members immediately began to share what they had learned. The positive feedback generated by these mini-presentations visibly pumped self-esteem into the mothers and grandmothers in attendance. Before the school year was out, the mothers were delivering the curriculum (rewritten to be age-appropriate) to sixth- and seventh-grade students at the invitation of the principal. What an exciting experience for all of us!

Now in year two, the grant has allowed us to expand our activities. We are able to offer the course to those who missed it initially, and this time, the teachers are neighbors. Additional work on developing the curriculum continues. A cost-share agreement with ACTION, the federal volunteer agency, helped us to hire two residents as VISTA volunteers. Several residents are undergoing treatment for drug abuse after obtaining help from our staff. Infant formula supplements are delivered to new mothers who need it. Residents meet twice weekly to discuss family values and to learn craft skills. With assistance from Morehouse Medical School's Cork Institute, we are developing a manual based on the discussions of family values. We are working with several adult residents and children in our "Just Say No Club" to plant and care for a vegetable garden. Arrangements with a local bank allow residents to cash their checks and bypass paying the exorbitant rates charged by check-cashing outlets. In February 1991, we took the program to a second public housing community in Atlanta; several of the residents trained in Bankhead Courts now teach and work in Techwood Homes.

What have we learned about parents in public housing? We confirmed that parents —whether they are rich or poor, young or old—care about their children. We've discovered that parents with little formal education can process complex information when it's something they want to understand. We've found that many residents of public housing need just the slightest encouragement to shine. We have discovered some of the inequities of the system and are finding ways to work within it while we attempt to make positive change. We are convinced that empowering parents with knowledge enables them to make change in their lives. And we believe that self-generated change lasts longer than change brought about entirely by outside intervention. □

*For more information about Inner-City Families in Action, call or write Sue Rusche, Director of National Families in Action; Harold Craig, Project Director; or Paula Kemp, Associate Director.*

*Contact them at: 2296 Henderson Mill Road, Suite 204, Atlanta, GA 30345 404/934-6364. FIA is a member of the Family Resource Coalition.*

■ by Abraham Wandersman and Robert M. Goodman

Community Partnerships for Alcohol and Other Drug Abuse Prevention

## The Problem

When residents in the Midlands—a four-county area of metropolitan Columbia, South Carolina—were asked in a 1990 survey about the major problems in their communities, they responded decisively: drugs. No other problem came in as a close second.

In the Midlands, nearly 60 percent of adults 18 and over regularly use alcohol. The number of admissions to our treatment centers reflect the severity of AOD abuse: For example, in two counties, admissions for alcohol treatment rose 77 percent in the last decade and drug admissions rose 107 percent. A similar pattern is repeated in the other two counties. Alcohol and other drugs are not just problems for treatment centers. They undermine our safety and contribute to crime and accident fatalities. Not surprisingly, risky behaviors have been passed along to the children. A survey was recently done on the extent of alcohol and other drug use by students in grades 7-12. In one county, almost 12 percent of seventh graders have at least one alcoholic drink per week. Nearly half of 12th graders use alcohol on a weekly basis. The numbers are similar for other counties. The problems cut across class and race lines and affect the whole community.

—From the *Midlands Summit Report 1991*

## A Proposed Solution: Community Partnerships for Substance Abuse Prevention

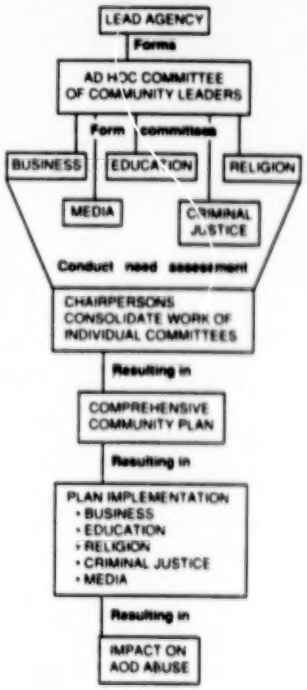
Premise: Alcohol and other drug (AOD) abuse, like most chronic health conditions, has multiple causes that are imbedded in our social fabric. While state and federal efforts are beginning to deal with the magnitude of the problem, it is at the community level that action must be mobilized to combat the complex issues involved. This means that the school, business, religious sector, media, health, academic, government, criminal justice, and grassroots community groups must coalesce as partners. It is only through large-scale, coordinated, and concerted efforts that communities will have a real chance to win the war against AOD abuse.

Recognizing the validity of such a comprehensive community approach, the Office for Substance Abuse Prevention (OSAP) has funded the development of partnerships in approximately 250 communities throughout the United States. These projects, each funded for five years, require that the community form a partnership, or coalition, of influential leaders and community members who will develop a comprehensive plan for reducing AOD abuse. The five-year funding provided by OSAP is innovative in that it allows time for each community not only to form a coalition and develop a plan of action, but also to implement their plan and evaluate its impact.

The authors are involved in evaluating two local community partnerships for substance abuse prevention; Figure 1 illustrates the model being used for their development. At the initiation of OSAP funding, the lead agency in each community convenes an *ad hoc* committee of local leaders who represent both the public and private sectors. These individuals in turn nominate influential citizens to sit on committees representing parents and youth, schools, businesses, religious institutions, the media, health, academic, government, criminal justice, and grassroots organizations. Each of the committees conducts a needs assessment to determine the extent and nature of its constitutents' concerns around AOD abuse. Based on the results, each committee recommends strategies for community action. The committee chairpersons are responsible for integrating all the strategies into one comprehensive plan which is then implemented through the coalition of organizations that was initially involved in developing the community plan.

Coalitions such as the OSAP partnerships are becoming a popular mechanism for mobilizing communities and for establishing and implementing health and social programs. For example,the federal government encourages the use of coalitions in chronic disease programs (the PATCH program of the Center for Disease Control) and cancer prevention (the COMMIT and ASSIST programs of the National Cancer Institute). While there is a great deal of common knowledge and a number of how-to manuals about operating coalitions, little systematic research exists on the characteristics of effective coalitions or how coalitions are formed and maintained. As the evaluators of two community partnerships,[1] we are most interested in going beyond the buzzwords of "collaboration," "partnerships," and "coalitions" to assess how community groups actually work together: we want to know how they form, cooperate, and sustain their operations.

**Figure 1.**
Model for Development of an OSAP Community Partnership




## Beyond the Buzzwords: Toward a Framework of Community Coalitions

Coalition defined: A coalition is "an organization of diverse interest groups that combines their human and material resources to effect a specific change the members are unable to bring about independently" (Brown, 1984).

When do coalitions form? Coalitions tend to form in response to a crisis, such as the drug and alcohol epidemic that spawned the OSAP partnerships. They also form in response to an unusual opportunity, like the sudden availability of grant funding. Coalitions can develop when resources are scarce or dwindling, or in times of necessity (e.g., to qualify for funding programs). When considering whether to form a coalition, community groups need to carefully assess what imperatives are operating that would entice others to join the partnership.

Why should I or my organization become involved? In general, individuals or groups join coalitions when the benefits of membership outweigh the costs of joining. Typical reasons for joining include: increasing access to resources; greater visibility, lobbying power, or political clout; inclusion in a network for infor-

mation sharing and support; learning new skills; greater recognition; and improving services. Costs of participation may involve time taken away from other activities, inconvenience, extra meetings, and perceived lack of accomplishments (Prestby, Wandersman, Florin, Rich, and Chavis, 1990).

In our evaluation of OSAP community partnerships, we are surveying coalition members to determine which of these benefits and costs have the most effect on member participation, satisfaction, and the development of a comprehensive plan for AOD abuse. If, for instance, increased political clout is an important reason for joining, a coalition can direct strategies that emphasize that benefit, such as including members' names on press releases and petitions to government officials. If time pressure inhibits joining, the coalition can work toward minimizing the cost by holding short but efficient meetings at lunch hours in mutually convenient locations.

We suggest that when forming a coalition, members clearly identify the organization's purpose. Is the community partnership mainly for information sharing, greater access to resources, greater political clout, or for a combination of these and other reasons? Once the reasons are understood, research who could benefit the most from such a coalition and what other groups are important to include that might need convincing? How can you advertise the benefits of membership in order to entice people to join while minimizing the barriers or costs of joining?

How do we maintain our coalition? Once formed, coalitions need to be nurtured so that they can mature and become fully operational. For instance, the OSAP partnerships were formed to develop a community plan, but their greater challenge will involve the actual implementation of that plan. Implementation requires sustained coordination and cooperation among groups that may not have worked together previously. For the coalition to have an influence on these groups, it must reach maturity and remain durable.

Few studies exist on the maintenance and viability of coalitions, but studies on voluntary and public sector organizations suggest strategies that can be generalized. For example, Prestby and Wandersman (1985) compared voluntary organizations that remained functional versus those that died out. They found that organizations with more potential resources, more structure (committees, by-laws, bank accounts, etc.), more activities, more attention paid to infrastructure (e.g., recruiting new members, training new leaders), and more accomplishments of initial and long-term goals were more likely to survive. Goodman and Steckler (1989) found that the more routinized an organization's operations become, the more likely they are to be sustained. Examples of routinization include regular work schedules, frequent staff meetings, and ongoing program planning.

When trying to *maintain* a coalition, we suggest that the following questions be addressed: Has the coalition developed permanent structures like by-laws, committees, and funding mechanisms? Have the coalition's operations become routine? Are meetings held on a routine basis? Do members routinely attend? Are members routinely informed about the coalition's work? Is a newsletter routinely sent to members? Do subcommittees continue to function on a routine basis? If the answers to many of these questions are "no," then the coalition should concentrate on developing the necessary structures and routines that insure its survival.

How can we assure that our coalition is *effective*? When assessing a coalition's effectiveness, it is essential to explore what community outcomes and impacts the coalition produces. For instance, the OSAP partnerships were initially formed to produce plans; part of our evaluation therefore, focuses on whether plans actually resulted and how good they are. A well-maintained coalition is not necessarily an effective one. After all, how many programs seem to last forever even if they're not worth the investment?

The following questions are important when assessing the quality of a coalition's planning effort: Does the plan specify objectives to be addressed? Are the objectives consistent with the goals of the coalition? Does the plan include specific activities that foster the goals and objectives? Are organizations identified that will take the leadership in implementing the activities? Are mechanisms specified for coordinating activities?

Assuring the adequacy of the plan is only a first step in community coalition effectiveness. In order for these coalitions to be ultimately effective, they must produce meaningful changes in the community. In the example of the OSAP partnerships, this means that AOD abuse is reduced. Important questions to address include whether the coalition's efforts increase community-wide knowledge of drugs and the perceived risk of drugs, whether they produce a reduction in overall drug use, a decrease in DUI arrests, a decrease in school disciplinary action for drug or alcohol offenses, and a reduction in the rate of new students starting drug use.

## Coalitions Can Change Communities

The purpose of the OSAP Community Partnerships is not only to help communities prevent and control AOD abuse, but also to be an example of how community life can improve when Americans value and work for their communities. The partnership is an exciting and timely experiment in large-scale community change. If successful as a strategy, this type of coalition may be applied to other complex challenges such as urban violence and crime, poverty and economic development, and quality education. Although it is too early to tell how useful coalitions may be in addressing such complex problems, we believe that continued and systematic study of well-funded coalitions is a step in the right direction that offers citizens a positive way to work together for the betterment of their communities. □

## Note

1. Our evaluation team includes graduate students Frances Butterfoss, Pam Imm, Heather Breiter, Matthew Chinman, Noelle Duvall, and Stephanie Wilson.

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■ by Lynn McDonald

# Families and Schools Together (FAST): A Prevention Program that Works

In 1990, FAST was presented with one of ten exemplary awards given to national programs by the U.S. Office for Substance Abuse Prevention. FAST is a unique alcohol and other drug prevention program—a collaborative venture between elementary schools, a mental health agency, an alcohol and other drug prevention agency, and families. It targets high-risk elementary school children using a family-based approach. FAST families are partners in an effort to empower them to become primary prevention agents for their own children.

FAST is structured to address four factors that have been correlated with adolescent substance abuse: parental substance abuse; low self-esteem; inability to discuss feelings; and lack of routines, rituals, structure, and communication.

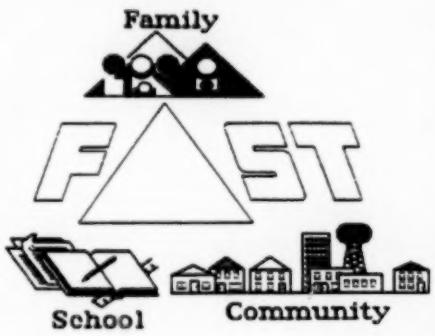
The children served by FAST are not yet involved in substance abuse but are referred through their teachers who find them at risk for school failure, juvenile delinquency, and alcohol and other drug use. Their families tend to be hard to reach in that they are usually poor, experience high degrees of environmental stress, have family histories of substance abuse, and have little contact with schools and community services. Approximately half the families served are from minority groups.

FAST recognizes the school as a hub in families' lives, and therefore creates a community within a community by bringing families in the same geographical school district together to participate in the program. Each family unit is seen as a team, and the entire program focuses on strengthening those teams and building family participation in a community network.

The program consists of multiple family meetings in two phases: eight weekly meetings followed by monthly meetings for graduate families that continue for at least two years. During the eight weekly meetings, up to twelve families have meals together as family units, engage in family strengthening activities, and learn communication skills; the parents meet as a support group while the children play separately. This is followed by: a parent and the at-risk child spending one-to-one quality time, which builds self-esteem for both participants; a lottery is held with one family winning as a family unit; and a closing activity, designed to provide positive and fun alternatives to using alcohol and other drugs, reinforcing family ties. The monthly meetings include a meal, a curriculum review, and an outing.

Each team meeting includes representatives from the schools, the alcohol and other drug prevention agency, and the mental health agency. Parents are continually exposed to the idea of being in equal partnership with other collaborative team members who want to assist the child at risk. The partnership dynamics build over the eight-week period. Parents settle into their responsibilities as primary agents of prevention for their own children, and the others are available to share tools and techniques that may be useful to parent partners.

Exposing families to information and resources in these meetings is seen as an important part of empowerment. When families are given information at a neutral time in their life cycle, they appear to be more open to listen and absorb. Having information creates choices; choosing creates empowerment. As parents share their experiences with each other, they learn about skills other parents have used successfully and a feeling of power is generated as they support each other.




FAST originated in Madison, Wisconsin in 1988. The program is based on family systems theory, stress/social support research, and techniques from child psychiatry. FAST is known for its careful and thorough evaluation. The program has empirical data which document success in (1) increasing the child's attention span and self-esteem, and decreasing behavior problems in the schools and at home, (2) strengthening parent-child relationships, enhancing overall family functioning, encouraging family networking, and (3) helping families feel more comfortable in their dealings with schools and other community resources.

Finally, the FAST program is currently listed in Wisconsin Act 122, the State's Antidrug Bill; $1 million is appropriated annually for its replication in communities throughout the state. A FAST Training Manual was developed to address replication of the program when used in conjunction with a 6 1/2-day training model. It contains strategies for dealing with each component of the curriculum as well as an appendix that includes all record-keeping instruments. National replication of the FAST program is in process. □

*Lynn McDonald, Ph.D., A.C.S.W., conceived the idea of FAST and is its Program Director. Contact her at Family Service, Inc., 128 E. Olin Ave., Suite 100, Madison, WI 53713 608/251-7611. Dr. McDonald is a member of the Family Resource Coalition.*

Voluntary participation is dependent on sensitive recruitment: getting the families to attend at least one program is necessary for the program's success. How do we do this?

1. We recruit the whole family in person, in their home, often accompanied by a FAST graduate.
2. We provide free transportation from families' homes to meetings and back again.
3. We provide a free meal for the whole family at the meeting.
4. We give out "FAST lottery" tickets and each family wins $30 worth of prizes in one of the weekly drawings.
5. We provide free childcare for infants and toddlers during the meetings.
6. We have a graduation ceremony in which the school principal awards certificates.
7. We hold monthly meetings for two years for whole families who have graduated from the 8-week program. Once in FAST, always in FAST.

■ by Pamela J. Thurman

# American Indian Families Build New Strengths on Ancient Traditions

Take the best of the white man's road, pick it up and take it with you. That which is bad leave it alone, cast it away. Take the best of the old Indian ways—always keep them. They have been proven for thousands of years. Do not let them die.

*—Sitting Bull*

American Indians have worked hard for better educational systems and a greater voice in federal decisions. Once again we have strong, positive role models and today there are many American Indian families who are resourceful and successful. For each troubled Indian youth, there are four who are healthy and successful. We gain strength in the knowledge that we have survived a multitude of obstacles that might have overwhelmed us—prejudice, poverty, and external control of politics, education, and law.

Yet, our struggle is not over. Literature accurately describes the destructive effects of alcoholism, drug abuse, suicide, social isolation, and violence in some American Indian communities. Even now, many Indians encounter social, economic, and environmental obstacles that severely block their potential for success. Chief Joseph once said, "All that we ask is an even chance," yet many Indian families never get that even chance.

The limited opportunities are compounded by substance abuse. For example, recent data from our Tri-ethnic Center for Prevention Research indicate that American Indian youth have higher rates of drug use than non-Indian youth for nearly all drugs, sometimes twice to three times higher! Earlier theories associated substance abuse with acculturation or deculturation stress, but this does not seem to be true for Indian youth today. In fact, the common threads associated with drug use are friends that use, and a weak link to both family and the traditional Indian value system. Why do our youth continue to use chemicals?

Many Indian communities or reservations are geographically isolated, restricting access to the economies that provide quality employment, enhanced job training, and prime educational opportunities. Urban Indians, on the other hand, face a different type of isolation—often living in poor areas of cities and towns, far away from family, friends, and meaningful tribal experiences. Such separations are very difficult because of their belief in and reliance on the traditional extended family system which has endured throughout time and continues to be a powerful and vital element of Indian life.

When economic conditions demand that families move away from the tribal community and the support of the extended family, there can be many consequences. It is essential, therefore, that agencies successfully serving American Indians build and strengthen the family by offering creative activities that honor and strengthen family values and traditions. Service professionals must provide families with opportunities to acquire the skills, expertise, and proficiencies of the dominant culture without displacing tribal identities or cultural support systems. This allows the American Indian his or her "even chance."

## Focus on Community, Family, and Tradition

As an example, there is a successful urban American Indian Prevention and Treatment Program in Tulsa, Oklahoma that is based on the traditional family concept. Its Advisory Board, established to oversee services and ensure cultural awareness, includes Indian professionals, media, elders, parents, and youth. The program center reflects the value of family —an older house that encourages the feeling of going "home" when one needs a warm and caring environment. Coffee is always available and this act, though small, maintains the Indian tradition of nurturing by offering food or beverage to demonstrate respect.

Because the majority of the families have limited resources, a collaborative referral effort has been implemented to provide assistance with basic necessities —housing, food, clothing, medical care, transportation, childcare, employment assistance, etc. After the necessities are met, families are encouraged toward a goal of self-sufficiency. Building confidence and providing opportunities for self-sufficiency are far more important than delivering a myriad of services that maintain dependence on the agency system. These opportunities are presented through carefully planned family events selected for adherence to cultural significance and literacy level. Activities focus on building interpersonal relationship skills, family communication, health and wellness, Tribal traditions, decision-making, anxiety reduction, and employability, all of which positively influence parenting without the guilt parents sometime associate with "parent training."

Traditional inter-tribal activities are also held regularly—community feasts on certain holidays, cedar ceremonies for prayer and purification, storytelling, and music. Other program events use cultural and drug-free themes for children's art shows. Youth are taught how to construct and use the sweat lodge and prayer ties. An Indian running club has been established as an alternative activity promoting wellness and the spirituality of running. Friday Family Night is a regular event that includes videos, food, music, games, and other interactive activities. These evenings allow the family to enjoy one another in a tribal or community atmosphere and provide subtle positive role modeling.

With the exception of Friday Family Night, childcare is offered while parents attend other center activities. Childcare not only supports attendance but has become a vital agent for early identification of developmental difficulties and increasing chances for remedial treatment as well as prevention of later school failure.

All the families are unique and each has an individual cultural experience that adds to the richness of the center. They demonstrate a great capacity to respond effectively to the problems they encounter, and each demonstrates numerous strengths that put them in touch with healthier ways of living. Although much is still needed to improve the quality of life for American Indian families, this program, as a first step example, provides an effective prevention framework for building greater opportunities. □

*Pamela Jumper Thurman, Ph.D., is a Research Associate with the Tri-ethnic Center for Prevention Research. A member of the Cherokee tribe, she has provided direct service in both treatment and prevention programs for American Indians and Alaska natives. Pamela has lectured nationally on substance abuse and mental health issues and provides technical assistance in program development and evaluation. Contact her at: The Tri-ethnic Center, Colorado State University, Department of Psychology—Clark Building, C-78, Ft. Collins, CO 80523 303/491-0251.*

# Parenting as Risk-Focused Prevention

The costs of substance abuse during adolescence and early adulthood are well known. For the developing young adult, drug and alcohol abuse undermine motivation, interfere with cognitive processes, contribute to debilitating mood disorders, and increase risk of accidental injury or death. For society at large, adolescent substance abuse extracts a high cost in health care, educational failure, mental health services, drug and alcohol treatment, and juvenile crime.

When my colleague, Dr. J. David Hawkins, and I began our work in the field of substance abuse treatment, most of the adolescents and adults with whom we worked had experienced the reinforcing effects of drugs. Most had also experienced school failure and had little commitment either to their education or to legitimate work. These adolescents were in serious conflict with their families; the adults were in serious conflict with their own families and were influencing a whole new generation to continue on the same path. Although we remained involved in and committed to improving treatment, our experiences in the late 1970s and early 1980s convinced us of the need for preventive action.

Unfortunately, many of the early attempts to prevent substance abuse had not been successful. For example, drug information programs did not always have the intended result—sometimes information about drug effects actually encouraged experimentation. On the other hand, the heart and lung disease prevention work being pioneered at Stanford University stimulated our interest in the effectiveness of targeting risk factors as an approach to prevention. When the researchers targeted such risks as a high-fat diet and lack of exercise, most studies found that as those risks were reduced so were sickness and death due to heart disease.

We adopted the same approach in our work on drug abuse prevention. We began by examining more than 30 years of research from a variety of fields, and we identified risk factors in each area of the child's world: the community, the family, the school, and the individual child. Following is a list of the risk factors we identified, from prospective longitudinal studies, as consistent precursors of adolescent substance abuse[1]:

- Laws and norms favorable toward use
- Availability of alcohol and other drugs
- Low attachment to neighborhood and/or neighborhood disorganization
- Transitions and mobility
- Extreme economic deprivation
- Family history of alcoholism
- Family alcohol and drug use and positive attitudes toward use
- Poor and inconsistent family management practices
- Family conflict
- Academic failure
- Low commitment to school
- Early and persistent problem behaviors
- Association with drug-using peers
- Alienation, rebelliousness, and lack of social bonding
- Youth's own favorable attitude toward drug use
- Early onset of drug use

In the literature we also found consistent protective factors—those that inhibit substance abuse despite exposure to risk. For example, research has shown that even when children are exposed to multiple risk factors, they are less likely to develop substance abuse problems if they have close bonds to people and social institutions with values against drug use.

Our approach to prevention—the Social Development Strategy—combines research information on risk and protective factors into a method for preventing substance abuse. The strategy's objective is to reduce risk factors in ways that enhance children's bonds to people and institutions that have norms against drug abuse.

Families can learn techniques to address the problems of drug abuse. Many of the risk and protective factors we have identified fall within the family's scope of responsibility and concern. *Family alcohol and drug use and attitudes toward use*, for example, exert an enormous influence on children's expectation to use drugs as well as their actual use. Alcoholism and illegal drug use within the family have been shown to increase the risk of alcoholism and drug abuse in children.

The risk of drug abuse also appears to be increased by poor *family management practices*. These are characterized by unclear expectations for behavior, poor monitoring of behavior, few and inconsistent rewards for positive behavior, and excessively severe and inconsistent punishment for unwanted behavior. *Family conflict* also increases children's risk for both illegal drug abuse and delinquency, and it is conflict itself, rather than family structure—including divorce—that places children at risk.

Risk factors having to do with children's behavior represent another area where parents can help prevent the development of drug problems. The behavioral precursors of drug abuse include *early antisocial behavior, association with drug-using peers*, and *early onset of drug use*.

Early and persistent problem behaviors are predictive of a variety of behavior problems in adolescence, including frequent drug use. The greater the variety, frequency, and seriousness of antisocial behavior in childhood, the more likely it is to continue into adolescence and result in other problems.

Friends who use drugs can be one of the most powerful influences in an early adolescent's life. As a result, peer drug use has consistently been found to be among the strongest predictors of substance abuse for youth.

Early first use of drugs predicts subsequent misuse: the earlier the onset of *any* drug use, the greater the involvement in other drug use and frequency of use. This being the case, parents need to know how to reduce early risk factors for drug *abuse* before their children have initiated drug *use*.

On the upside, *bonding to family* is an important protective factor against adolescent substance abuse. Positive family relationships, characterized by involvement and attachment, appear to protect youths from developing a substance abuse problem. In fact, the most important

predictor of a drug-free adolescence may be strong ties to parents who express clear norms against drug use. Surveys consistently show that when children refuse drug offers, the reason they usually give is "my parents." Our research has shown that family bonds of attachment, commitment, and belief combined with the message that drug use is not acceptable can make a difference.

### Parents as Change Agents

How can parents be empowered to reduce their children's risk for adolescent substance abuse? One way is through parent education programs that teach families techniques to strengthen bonding and communicate norms against drug abuse.

*Preparing for the Drug Free Years*,[2] described later in this issue (see Resource File), is an example of such programs. It is a risk-focused workshop for parents of elementary and middle school children that is part of a comprehensive experiment in school-, family-, and peer-based drug abuse prevention. As we designed this program, we developed criteria for effective parent workshops to prevent substance abuse. These same criteria can be applied by anyone seeking effective parent programs to prevent drug abuse:

- **Begin early, before children start drug use.** Primary prevention means reaching parents of children prior to the middle school years, when high rates of drug use are initiated.
- **Address risk factors that can be changed by family action,** such as the family and behavioral factors detailed above.
- **Involve high- and low-risk families together.** In this way you don't stigmatize any of the families and children who participate in the program. This approach also helps high- and low-risk families talk to each other and learn from each other.
- **Enable parents to decide whether and how to apply aspects of the program in their own homes.** Parenting programs can make a difference only if parents apply what they learn, which they will do only if they find the material sufficiently compelling. This criterion highlights the need for program relevance across lines of culture, education, and social class.
- **Strengthen family bonds.** All program activities should be aimed at increasing opportunities for family involvement and contribution, skills for effective involvement, and recognition for skillful involvement. In this way, bonds between family members will be strengthened. To the extent possible, the programs themselves should bring parents and children together. The more family involvement around the program material, the greater the likelihood that the program will increase family bonding.

But how do we persuade families to come to workshops? This is a tremendous challenge which demands nothing less than changing the social norms about parent education.

If programs are to be successful, parents must feel good about getting involved in them. Their peers should see these parents as smart consumers of information who care about their families and are taking steps to do the right things for them.

Parent education must become as popular as the fitness movement. Everyone should be talking about how they are reducing their family's risk for drug abuse, just as they currently talk about how they are reducing their families' risk of heart disease through changing diet and exercise habits.

I think my personal objective should also be yours: to reach all parents—whatever their history of drug use, their culture, their reading level—who want to prevent their children from using drugs. Here are some tips to help reach those families and draw them into workshops:

- **Use the media.**[3] Some possible approaches are public service announcements, local news stories, and televised workshops. A campaign title, logo, or theme can be very important in capturing people's attention. Keep it positive!
- **Remove barriers to attendance.** Make it easy to come to workshops—arrange a convenient location and time, child care, and help with transportation.
- **Be sure the experience is appealing.** Choose a comfortable, attractive setting and offer refreshments. Provide incentives to the children—interesting childcare, poster contests, special treats for school classrooms that recruit the most parents.
- **Personally recruit parents and get others involved in recruitment.** Nothing substitutes for personal contact. Call on well-known figures from the community to join you. Recruit others who will get involved in contacting parents—teachers, principals, students, other parents. When programs are offered through the school system, get children to write letters home to encourage their parents' involvement.

Parents can become agents of risk-focused prevention in their own families when they are provided with (1) a clear understanding of the factors placing their children at risk for drug abuse, and (2) solid techniques for reducing the risks and strengthening protection. Our objective must be to reach and empower all parents who want to protect their children from substance abuse. □

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# The Elusive Goal of Parenting

■ by Sue Blaszczak

Preadolescence and adolescence are noted as times of ups and downs and emotional trauma. For many parents of those children, that is especially true. Remembering the days of having three teens a year apart, I feel qualified to make that statement.

Early on, I would look around and wonder if all those parents with children the same ages were really as calm and efficient as they looked. From the outside it appeared the majority of the families were sailing through, unaffected by parenting adolescents. They all talked about their children, but only about safe subjects —and nice subjects. The conversations felt guarded.

That was different from when the children were little. Then, it was okay to share stages and phases and concerns. Then, we were all anxious to call about events and overnights and birthday parties. Where had all the communication gone?

Were all those other kids angels, I wondered many times? Did those parents have a combination that we were missing? Were there secrets that they read about in special magazines, or did they mix with the people who had all the answers?

Slowly, I began to feel we were outsiders. Parenting adolescents seemed a lonely place to be. On any given day, there was a child in our home testing the system, challenging the rules, stretching the curfew, expressing dislike over our decisions, or trying to manipulate us with kid pressure.

The kid pressure was the worst. "You are the only parents that have those kind of rules," "I'll never have any friends because of you," "Everyone else's parents said they could go," "If you chaperone, I'm not going," and on and on. Indecision prevailed, along with feelings of guilt for being either too strict or not following gut feelings and being strict enough.

There was another problem, too. Something was missing. The family was busy. A dad working full time, a mom working weekends. Three teens, and a toddler besides. The days were busy, the weeks were busy, there was school and sports, lessons, church, shopping, chores, and so many other things to think about.

It occurred to me that maybe we were looking at parenting these children in a very nearsighted manner. We were dealing with parenting on an everyday basis, but not giving a lot of thought to long-range goals. Actually, I'm not sure at that point we ever stated any goals at all as parents. It was a profession we really had not been prepared for. No handbooks, no in-service.

Looking around for assistance, it became clear that most parenting classes required long-term weekly commitments that, with our schedules, we were not able to give. I began looking for written information and found a lot of good theory but little that dealt with long-range goals or practical help for everyday problems.

One evening a local school hosted a speaker, a man who described his frustration as the father of five children. He felt parents who had children who were friends should be talking to each other regularly about rules and guidelines, curfews, and concerns. Concerns like: Who was chaperoning the party, and did they agree on what that meant? Did the host parents approve of youth drinking? How and by whom were the children being transported? Was this a safe place for the children to be?

My thoughts exactly! I approached him and found that there had been a few attempts to set up a communication system in area private schools, but nothing else. He called the effort "Parents' Communication Network."

I took the information he had, went home, and immediately took a risk. I called twenty parents of my teenagers' friends and asked them if they were willing to get involved in an effort like this. I was absolutely amazed and pleased when everyone of them said yes.

We began to put together additional information and widen our networks, specifically addressing problems of alcohol and other drug use and all related youth issues. We set up networking systems in schools and with sports teams and other school groups. What a relief to find out there were other parents out there who had similar problems and concerns!

It became clear that parenting skills and prevention skills went hand in hand. It also became clear that many parents not only lacked correct information regarding alcohol and other drug use and abuse, but they were reluctant to seek that information unless the "adult positive peer pressure" factor was present. In other words, if the majority of parents were calling each other about where the children were going, it would be acceptable, under peer pressure, for them to do the same.

With a little empowerment, parents began to communicate with each other and to educate themselves in the skills they needed. They sponsored safe activities for their children, and found ways to begin changing the community environment to support the children in growing up alcohol and drug-free.

DASA: Illinois Department of Alcoholism and Substance Abuse

As I watched the system begin to work for parents, and watched my older children grow to young adulthood, I believed I had found the missing piece that had eluded me for many years: all the things we were teaching parents were wonderful and correct and appropriate, but we needed a better perspective on why we were doing all of those things.

It became clear that our Parent Communication Network was in existence because we wanted our children to grow up to be the best they could be and able to get along without us when they left us. It was evident that on a daily basis, in the midst of our busy schedules, we needed to be sure we were parenting to meet those long-range goals. And if we *were* parenting to meet those long-range goals, we were also being good prevention practitioners.

Today I begin my nearly daily speeches to parents with "What is really our goal as parents?" Then I begin to talk to them and empower them. I give them the best information I have to help them accomplish their goal as parents. And I am simply there for them, just as I wish someone had been there for us when we needed it most. □

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■ by Patricia Nelson, Ora M. Gibbs, and Donald G. Unger

# Families Matter!

Families Matter! is a community-based program for low-income, high-risk families that is designed to strengthen parents' use of effective strategies to prevent their youth from abusing alcohol and using illegal drugs. Families Matter! accomplishes this goal by providing support and education to parents, with a range of opportunities for program involvement. The development of this program was guided by principles which make prevention programs for families effective: (1) comprehensive and flexible services; (2) staff who have the time, commitment, training, and skills necessary to build relationships of trust and respect with families; (3) a focus on the child as part of the family, and the family as part of the community; and (4) programming that evolves according to the needs of families.[1,2]

Families Matter! is one of three components of a substance abuse prevention program in Wilmington, Delaware used to develop competent youth, supportive families, and caring communities. The program is being implemented by a consortium of community centers.

The first component, the Youth Connection, is offered after school and during early evening hours. Youth participate in activities that promote physical well-being, help them to understand and communicate their feelings, handle peer pressure, make healthy decisions, and learn social skills. A full-time coordinator works with the youth along with Peer Helpers—generally 13-15 years of age—who act as role models for younger children. Activities related to ethnic and racial heritage are an integral part of the youth program.

The second component, community empowerment, is currently being implemented to create neighborhood coalitions that actively support positive youth development. A community consortium will coordinate and generate resources needed to accomplish the goals of these coalitions.

In Families Matter!, the third component, paraprofessional Family Coordinators work twenty hours per week with the families of children enrolled in the Youth Connection programs. Parents have opportunities to participate in Families Matter! through weekly personal contact with their Family Coordinator via a home visit, telephone call, face-to-face talk, and/or personal letter. In addition, at least one parent meeting and one combined parent/youth activity are held every month in the community centers, providing opportunities for parents to interact with each other. Finally, a monthly age-keyed parent education newsletter is sent to each family. These strong outreach components offer support and encouragement, reinforce positive parenting skills, help families identify and use community resources, and encourage participation in group activities.

The variety of opportunities for parental support and education are designed to help parents identify the individual strengths and resources that they bring to parenting. Parents also learn how to increase or strengthen their monitoring of youth activities, set clear, reasonable limits for their youth, praise and encourage their youngsters, and spend quality family time. Family Coordinators assist parents with improving family communication, conflict management skills, home-school linkages, and their use of social support networks to strengthen family life.

Family Coordinators are very special, caring people who are good listeners. They are patient and persistent, removing barriers that prevent families from getting help and then linking families with services in the community. Coordinators work hard to gain the trust of families, knowing this is an important and difficult task to accomplish. Family Coordinators live in the neighborhoods they serve, and this shared background helps them understand and relate to the diverse cultures, lifestyles, and histories of their assigned families.

Some of the most important components that contribute to the success of Families Matter! include: (1) a program design that recognizes there will be different types and levels of family involvement; (2) weekly, personal contact with parents; (3) easy availability of Family Coordinators; (4) ongoing support for Coordinators through monthly meetings to provide in-service education and support, to learn of resources available in the community, to praise and encourage Coordinators, to discuss suggestions for improvement, and to meet monthly with the Senior Family Coordinator; and (5) close collaboration with the Youth Connection program.

Parents are made aware of the goals and activities in the youth program and efforts are made to integrate what youth are learning into programming for parents. The most effective Youth/Family Coordinator teams have weekly meetings to plan and discuss activities.

Some of the challenges that Coordinators face are low parent participation and irregular parent attendance at meetings; the basic problems have to do with transportation, working hours, low social skills, and low self-esteem. Families Matter! has eliminated some of these barriers by providing babysitting, refreshments, and occasional transportation.

The Families Matter! program was developed as part of a demonstration grant funded by the Office for Substance Abuse Prevention, and spearheaded by the Director of Delaware's Office of Prevention with major input from nine of Wilmington's publicly and privately funded community centers. More than 700 low-income families have participated in the Wilmington program in which most of the parents are single and African American. After initial success, the program has been implemented in six rural Delaware communities.

The Families Matter! program is one way to design parent involvement components in substance abuse prevention programs that are responsive to the diverse needs of families. Families Matter! is not dependent on parents coming to group meetings, nor is it solely a one-on-one program that deprives parents of the opportunity to gain crucial support and encouragement from other parents. While the challenges of working with high-risk, low-income families are innumerable, the need is great. The Families Matter! program is a family resource model that we believe can help meet the needs of families and their communities. □

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■ by Ivy Spataro

# Family Involvement is Key to Successful Worksite Treatment and Prevention Programs

Forty years ago, Employee Assistance Programs (EAPs) began to appear in corporate America. Back then, they were known as occupational alcoholism programs and focused specifically on the problem of alcohol abuse. The goal was to use constructive confrontation with the employee and impose an ultimatum of "shape up or ship out."

Many changes in American culture and family life have occurred over the ensuing years, particularly the growing number of families in which both parents work outside the home, and the rapid increase in working single parents. EAPs have responded by broadening their program focus from rehabilitating the alcohol user to assisting employees and their families with a whole range of personal and family problems. Still, substance abuse remains one of the most critical problems affecting family life.

## An Overview

The Employee Assistance field has developed a core technology that distinguishes it as a unique profession. Most EAPs offer the following basic services:

- In-person counseling and telephone advice for employees and their family members; often a limited number of sessions are offered in order to provide a comprehensive assessment and linkage to ongoing services.
- Assistance with implementing the program, including development of EAP policies, procedures, and materials.
- EAP management training and case-by-case consultation to help supervisors make effective referrals.
- EAP orientation and refresher sessions to assist employees in accessing the program.
- Lunch and learn educational seminars
- Consultation for program viability and ongoing evaluation
- Utilization reports

In a period of stringent cost control, EAPs have had to prove their effectiveness and potential. In 1988, McDonnell Douglas commissioned a landmark study of its Employee Assistance Program and found that it did in fact save four dollars for every dollar spent. In general, the savings resulted from a reduction in absenteeism, accidents and workmen's compensation claims, and a decreased need to hire and train new employees.

While this study is evidence of the positive effect EAPs have on both employers and employees, the programs must still justify their existence—especially when costs of rehabilitating employees continue to rise. Thus, more recent attention has been given to prevention and early intervention efforts.

A key way EAPs provide preventive services is through their participation in wellness programs at the worksite that address a range of health-related issues—both physical and mental—which, if successful, will result in cost savings to the company (e.g., in reduced insurance costs). EAPs often sponsor educational seminars during the lunch hour on topics such as stress management or drug abuse. Seminars of this type provide useful information that not only contribute to employees making healthier choices for themselves and their families, but also serve as a means of marketing EAP services and reaching some employees before their problems are of crisis proportions. Proof of the actual cost-effectiveness of wellness programs is more difficult; nevertheless, commitment to these efforts is increasing.

The core service of EAP programs continues to be professional assistance for a range of personal problems that impact on job performance. Currently, most EAPs describe their focus as broad-brush, meaning that the program addresses the full range of personal and family problems encountered by employees. In addition, most EAPs have also expanded their service delivery to include employees' family members. A variety of methods are used to successfully accomplish these efforts, including targeted promotions to family members and the use of professionals trained in family treatment who can provide the assessments and referrals.

## How EAPs Combat Substance Abuse in the Workplace

While EAPs have always maintained a focus on combating drug abuse in the workplace, providers are finding that a strong family component is key to addressing the problem. There are several ways in which family involvement in these programs occur:

1. Substance abusers are often the most difficult people to reach since the primary symptom of the disease—denial—means that the individual does not recognize he or she has a problem. The family, on the other hand, has often been in pain for a long time and is ready to reach out for help. Thus, an EAP that encourages family involvement can eventually access the employee through the family member who is motivated to seek assistance.
2. EAPs with strong family components help to develop a more rounded assessment of the employee's problem. Often the substance abuser is so impaired that it is difficult for the EAP counselor to clearly identify the exact nature and extent of the problem. By including family members in the process, the counselor is better able to provide an accurate assessment and the most effective treatment referrals, therefore contributing to the family's best chances of long-term recovery.
3. EAPs treat substance abuse as a family problem and involve the family in the solution. Family therapists believe that, in most cases, each member of the family assumes a specific role that propels the substance abuser. For example, spouses of alcoholics often become co-dependent, creating obstacles for the substance abuser in recognizing that he/she has a problem—a step that is crucial before recovery can take place.

## Conclusion

Substance abuse is one of the most challenging problems faced by all sectors of our society. While EAPs at the worksite have an excellent vehicle for motivating the substance abuser to seek help—the employee's job stability—a truly effective EAP must go one step beyond. The program has the opportunity to not only use the power of the family to reach an employee in trouble, but it can also help family members participate in the process of rehabilitation. Hopefully, in the future all EAPs will be asked to demonstrate their commitment to family involvement as a measure of their success. □

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# DASA: A Model for Community Substance Abuse Prevention

■ by Barbara Cimaglio

**Alan Markwood is a busy man.** As a Prevention Area Coordinator, he wears many hats while working with local agencies, government units, schools, the media, and community organizations in nine counties to ensure successful prevention efforts. The Prevention Area Coordinator is the point person in Illinois's model InTouch prevention system which is administered by the Illinois Department of Alcoholism and Substance Abuse (DASA).

DASA believes alcohol and other drug abuse is a public health problem. As we strive to promote healthy lifestyles among Illinois citizens, it is clear that health promotion and disease prevention must be addressed through strong community-based prevention programs. In Illinois, we have spent the past several years building a prevention network that depends on coordination—from the federal government to the neighborhood parents' group and the family. There are several different types of DASA-funded prevention programs in Illinois:

## Comprehensive Programs

Comprehensive grants are awarded to community-based agencies that provide prevention activities to locally defined service areas such as counties, townships, and the Chicago community areas. Services must target the total population, youth and adult, and be available throughout the community. Specific activities must be based on the five nationally accepted prevention strategies: information, life skills building, alternative activities, social policy awareness and change, and impactor training.

## The InTouch System

InTouch (Illinois Network to Organize the Understanding of Community Health) is a management system designed to bring together community prevention efforts. Started in 1985 as a collaboration between the DASA, the Illinois State Board of Education, and the Office of the Lieutenant Governor, the model was developed to join schools and communities into Regional Prevention Groups (RPG).

## Innovative Programs

The Innovative grant program is a kind of incubator for new prevention ideas that are funded through special initiatives to provide particular services on a local level. These programs are intended to be demonstration projects for new ideas and strategies in prevention. In FY 90, funded programs were directed to high-risk minority populations, with a focus on projects targeted to residents of housing projects. All of these projects are evaluated for success and effectiveness.

Several of the Innovative Programs are now integral parts of the system. Most notable are ten prevention programs in public housing communities across the state. The initial project, funded in the city of Danville, gave us a site in which to develop and evaluate a model which is now being transferred to other communities.

## Statewide Training

Training grants are intended to support projects that will have an impact on and be accessible to persons across the state of Illinois. Training programs address the diverse needs of the prevention field and focus on multiple prevention strategies. Training is handled primarily by the Prevention Resource Center (PRC) which was formed as part of the InTouch System.

Research tells us that education alone is not effective in preventing alcohol and other drug abuse among youth. To have a greater chance of success, prevention efforts have to encompass multiple strategies as outlined above. Training, therefore, is necessary to move communities to a point where they can develop effective prevention programs. PRC is funded to provide resources, training, and technical assistance in collaboration with InTouch. PRC has a library of prevention resources in Springfield and a Chicago branch specializing in resources for people of color. A series of basic or baseline prevention awareness and program development trainings are offered for prevention professionals and community prevention team members. These trainings include: an introduction to alcohol and other drug abuse prevention, community team training, mobilizing communities for change, and how to implement baseline training at the local level.

In addition, ongoing training is offered in special topics such as parenting, youth development, and community development. PRC coordinates the resource needs that are identified by communities as they refine their prevention efforts.

## Youth Development

The success of youth development programs that are part of the InTouch system shows the positive effects of community-based prevention. The Illinois Teenage Institute (ITI) and Operation Snowball, Inc., are prime examples. More than one thousand teenagers attended ITI in 1991 to learn how to develop leadership skills. Many of those teens went home and served as role models in Operation Snowball chapters. Snowball is a network of community prevention programs which evolved from ITI. Volunteers conduct weekend retreats and youth leadership training programs. Snowball has an 18-member Board of Directors which functions as an advocate and educator of youth. It has grown to at least 83 chapters throughout the state. Both ITI and Snowball are sponsored by the Illinois Alcoholism and Drug Dependence Association, and IADDA serves as the clearinghouse for information on the Snowball program. Many of the Snowball board members are also part of InTouch, which further strengthens the coordinated and comprehensive approach to prevention in Illinois.

## Working Together

Prevention, supported by DASA and the InTouch System, has truly become a force for community change, but altering norms and values about alcohol and other drugs is a long-term commitment. For Alan Markwood and his staff, sustaining that commitment means that on any day or evening they may:

- assist a local prevention agency in one of the nine counties in their Prevention Service Area
- make connections between overlapping local, state, and federal prevention initiatives
- gather and report information on current local prevention activities
- help to organize and advise a local or regional volunteer prevention group
- write material for the InTouch newsletter
- set up or publicize prevention training events
- respond to inquiries for prevention information, materials, and referrals
- participate in public policy advocacy efforts.

The InTouch system provides the structure through eighteen Prevention Service Area Coordinating programs, the resources and training through the Prevention Resource Center, and the program activities and services through the more than 125 local community-based agencies funded by DASA. The DASA-supported prevention system, with InTouch as the cornerstone, is a model of how communities can work together to bring about change. □

*Barbara Cimaglio is the Administrator of the Prevention Division of the Illinois Department of Alcoholism and Substance Abuse (DASA).*

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■ by Jean Ann Linney and Abraham Wandersman

# Useful Evaluation for Community-Based Prevention Programs

There are thousands of prevention programs and activities ongoing across the country in small towns, suburbs, and major urban centers. While program providers and participants are generally enthusiastic, they may have difficulty convincing funding sources that their programs are effective. Increasingly, program developers, citizens, and funding sources are calling for documentation and systematic evaluation of these programs. Particularly in the area of prevention of alcohol and other drug abuse, substantial resources have been devoted to programs; but for the majority, we have little information about their effects. Program evaluation can address many unanswered questions: Do the programs work? To what extent are they able to accomplish their goals and objectives? What are the barriers to program implementation and program effectiveness?

While the call for evaluation grows louder, many of those who are implementing programs in local communities either lack the resources to conduct extensive evaluations or feel they do not have the skills and expertise to design or complete a program evaluation. In response to these grassroots needs, the authors have developed a user-friendly program evaluation workbook to benefit those who provide preventive service activities.

The workbook is structured around a four-step approach to evaluation (see Figure 1). *Step 1* is to Identify Goals and Desired Outcomes. *Step 2* is Process Evaluation, which involves the documentation of: (1) the activities undertaken to accomplish a goal or to bring about a desired outcome, (2) the obstacles to implementation of the program as planned, and (3) the target groups served by the program. *Step 3* is Outcome Evaluation, and it includes documentation of what happened as a result of the program and its immediate effects. *Step 4* is Impact Evaluation, or the examination of the ultimate or longer term effects desired by a program. A family life education program, for example, might result in the immediate outcome of increased knowledge about conception and contraception (Step 3), with the ultimate effect (or impact) of reduction in the rates of teen pregnancy (Step 4).

Most programs incorporate these four steps (goals, activities, outcomes, and longer term effect), but often they are not specified beforehand nor recorded in a systematic way. We find that service providers understand the logic of evaluation, but often have difficulty putting the information into a program evaluation format. To reduce these barriers, the evaluation workbook identifies common approaches to prevention (e.g., a public awareness campaign, parent training program, school-community partnership), and provides a set of worksheets for each prevention approach. For each type of program, there is a worksheet module which follows the four-step evaluation model—individualized for the specific prevention program being evaluated—with room for modification to reflect the specifics of local efforts. The worksheets identify common goals and desired outcomes and suggest useful process evaluation data to record, as well as suggested instruments for each of the outcomes identified.

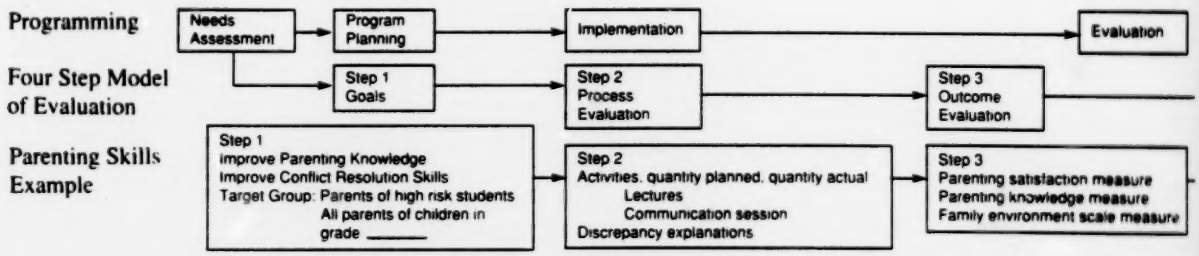
## How Does All This Apply to a Real Program?

The example that follows describes a parent training program for the prevention of alcohol and other drug use among teens. The goals, process indicators, outcomes, and impacts are identified in parentheses. The bottom of Figure 1 outlines the four steps in this example:

A Parent Skills Training program was developed by the local Community Mental Health Center at the request of the McLinman High School administration. Many of the students at the school who got involved with drug and alcohol use came from families experiencing high degrees of family conflict and low levels of supportiveness for the child. In addition, the Community Mental Health Center staff became aware of research evidence that youth who get involved in illicit drug use often come from families with poor discipline, poor parent-child communication, and low family cohesion. Students from families experiencing high degrees of family conflict and low family cohesion were considered to be at high risk for drug and alcohol use (target group-Step 2).

With this information in mind, the staff of the Mental Health Center and the school's staff decided to adopt the XYZ Parent Skills Training curriculum. They thought that if the training improved the parent's parenting knowledge and conflict resolution skills (goals—Step 1), then these high-risk students would be exposed to less stress and to a more cohesive and supportive family environment (goals—Step 1). They felt that if the parent's par-

Figure 1.



enting knowledge and skills improved (outcome—Step 3), then drug use among the high-risk students would be reduced (Impact—Step 4).

The parenting program was planned to comprise 16 sessions, each lasting one hour, and presented one evening a week at the high school (activities, quantity planned—Step 2). The first two sessions would introduce the parents to the philosophy of parenting skills. Special attention was focused on setting limits on the child's behavior while fostering the child's self-reliance and ability to cope with his own problems. A special session was developed by the mental health center and school staff which presented a videotape on recognizing indicators of child and adolescent drug and alcohol use and discussing how parents could effectively respond to suspected use. The next three sessions would develop communication and conflict resolution skills needed to put the parenting skills philosophy into practice. The last ten sessions would focus on practicing and role-playing communication and conflict resolution skills with a variety of problematic parent-child situations. Unfortunately, only five of the ten practice and role play sessions were actually conducted because of bad weather and scheduling conflicts with the school district (quantity actual/discrepancy explanations—Step 2).

Step 4
Impact
Evaluation

Step 4
Alcohol or drug related incidents
of children of program participants

The XYZ program was announced to all parents through a school mail-out. The goal was to have 75 program participants (quantity planned—Step 2). The intention was to have a group made up primarily of parents of high-risk students, but other parents could participate if space was available. Sixty parents attended the first session but only 10 of these 60 parents appeared to be from high-risk groups (quantity actual/targeted group missing—Step 2). The trainers were told by some participants that many of the parents not attending had no transportation, worked at night, had no safe place to leave their children, or were single parents who feared that everyone else would be couples (discrepancy explanations—Step 2). Ten parents, 6 of them high-risk, dropped out of the program before it was completed. A parenting satisfaction measure (outcome measure—Step 3), given to all participants before and after the XYZ program, indicated an average gain of 30 percent in parent satisfaction.

Several additional tests were given after the XYZ program was completed. Participants averaged a score of 85 percent on a standardized test of XYZ parenting knowledge (outcome measure—Step 3). The family conflict questionnaire and the Moos Family Environment Scale (outcome measure—Step 3) norms indicated that the XYZ participants scored at the 30th percentile on conflict and at the 75th percentile on family cohesion. A check of school disciplinary records indicated that none of the children of program participants were involved in drug- or alcohol-related incidents (impact indicator—Step 4). In addition, all parents reported positive attitudes toward the XYZ training experience on a workshop evaluation form.

To evaluate this type of program, evaluators could use the worksheet module for "Parenting Skills Training." The *Step 1* worksheet guides the evaluation team to identify program goals. Common goals for parenting skills programs such as "improve parenting skills" and "reduce parent-child conflict" are preprinted on the worksheet with space available for the evaluation team to add additional goals unique to their situation.

The *Step 2* worksheet guides the team through documentation of the number of training sessions planned, the targeted audience, consideration of who was missing, and what might have been obstacles to successful implementation. Common aspects specific to parenting skills training are preprinted on the worksheets. The *Step 3* worksheet shows the goals identified in *Step 1* with suggested measures for each goal (copies of the measures are included in the workbook). The evaluators are instructed to record data from pre- and post-assessments in specified columns, along with any data from comparison groups. Instructions are provided to guide analysis of these outcomes to determine program effects.

*Step 4*, the Impact Evaluation worksheet, identifies 7 indices of the desired impact of drug and alcohol prevention programming. The workbook provides suggestions on where to get these data and encourages comparisons both of pre- and post-program scores and comparisons with other similar settings that did not implement these programs (control groups).

This workbook has been used by community groups throughout the Southeast with very positive feedback. Many schools and community teams have used the materials for program planning. Novice evaluators report that the workbook helped to reduce their anxiety about evaluation by providing a concrete framework from which to begin to structure the evaluation activities. The workbook is not intended to be a handbook for how to conduct sophisticated evaluations of model research and demonstration programs that test theories and hypotheses. Rather, the materials are designed to encourage and facilitate evaluation efforts and to build evaluation capacity at the local level and to provide programs with procedures that will be useful for program management, resource management, and accountability. These evaluations can provide ongoing feedback on program implementation and resource allocation.

Preparation of the evaluation workbook was initiated in 1989 by the Southeast Regional Center for Drug-Free Schools and Communities in Atlanta.[1]

The original workbook has been revised and is being published by the Office for Substance Abuse Prevention as *Prevention Plus III: Assessing Alcohol and Other Drug Prevention Programs at the School and Community Level—A Four Step Guide to Useful Program Assessment.* It should be available (free) early in 1992.[2] While the workbook is specifically targeted to programs for the prevention of alcohol and other drug use at the school and community level, many of the worksheets are designed for family resource-type programs. □

## References


1. LINNEY, J.A., McCLURE, L.F. WANDERSMAN, A. with COBBS, M., STARNES, D., and STERLING, T. *Evaluating Alcohol and Other Drug Prevention Programs at the School and Community Level.* Southeast Regional Center for Drug Free Schools and Communities, 1989.
2. Available from the National Clearinghouse for Alcohol and Drug Information (NCADI), P.O. Box 2345, Rockville, MD 20852.



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■ by David L. Giveans

# Reel-to-Reel

# Films and Videos on Substance Abuse Prevention

The following selection of current films and videos is a sampling of the varied material available for young children and adolescents, parents, and the professionals who work with them.

**Addiction: The Problems, The Solutions** *(1990, 30 mins., video only).* Teenagers often fail to realize the complexities of addiction: what it is, who is vulnerable, why an addiction is so hard to kick, and what can be done. In a series of interviews with young people, a medical experi, and a psychologist, this video examines the whys and hows of addictive behavior to make viewers aware of what being addicted really means. Video discusses types of addictions—process and substance—signs of addiction, and cross-addiction. Study Guide. *Sunburst Communications.*

**America Hooked on Drugs** *(1986, 20 mins., 16mm/video).* Report produced by "ABC Nightline" and hosted by Ted Koppel explores the prevalence of drug use in America—its debilitating effects on the human brain, the personal costs, and the loss to business in declining productivity. In candid interviews, former drug users reveal how drug abuse disastrously affected their lives. *MTI Film and Video.*

**America Hurts: The Drug Epidemic** *(1987, 34 mins., 16mm/video).* An eye-opening look at the long-term implications of a society where a morally corrupt drug industry provides an enticing model of easy financial success. The growing menace of cocaine, crack, marijuana, PCP, and "designer drugs" is shown to extend far beyond the user. The expanding circle of devastation includes families, communities, and entire nations. Interviews with authorities explain how impoverished supplier nations are held virtually enslaved by the demands of the drug industry and how the efforts to meet those demands are destroying law and order, farming lands, and the lives of innocents. *MTI Film and Video.*

**Bodywatch: No Butts** *(1987, 30 mins., 16mm/video).* Despite years of health warnings, millions of Americans continue to smoke. The pleasures behind smoking, both psychological and physical, are presented as well as the newest and hardest facts about second-hand smoke and the effects of parental smoking on children. Examines successful strategies for quitting the habit for good. *MTI Film and Video.*

**Breathing Easy** *(1984, 30 mins., 16mm/video).* LaVar Burton, Mark Harmon, and Joan Van Ark appear on the "Breathing Easy" network which presents up-beat programs that extinguish the glamorous myths about smoking and encourage preteens and teenagers to "be well, stay well, and make the choices that will make their lives the very best they can be." This non-smoking film is bound to be accepted by viewers. *MTI Film and Video.*

**Coke Isn't It: Hard Facts about Cocaine** *(1989, 26 mins., video only).* Live action vignettes and an interview with a medical doctor provide the hard facts about cocaine use. These include the extreme physical and psychological effects of the drug, the popular misconceptions involving cocaine, and a discussion of the "business" of cocaine use. *Guidance Associates.*

**Drug Free Me** *(1990, 15 mins., video only).* This video helps chidlren (grades K-3) understand the difference between medicine and illegal drugs; from whom it is appropriate to take medicine, and that they can talk to adults about their problems. Third graders' art work depicts their thoughts and feelings regarding tobacco, alcohol, and drugs. Tempsett Bledscoe from *The Cosby Show* is featured in one segment. Study Guide. *Select Media.*

**Inhalant Abuse: Kids in Danger/Adults in the Dark** *(1990, 18 mins., video only)* A video about the growing abuse of *legal* substances by children: spray paint, nail polish remover, colored markers, and 600 legal substances are deliberately used by seven million children! Video offers telltale signs of inhalant abuse, how children conceal their inhalant abuse, and practical prevention steps. Study Guide. *Media Projects, Inc.*

**Kids Talking to Kids** *(1989, 17 mins., video only).* Effective viewing for children 9 years of age through high school. Through interviews and scenes from their lives, five children discuss their experiences in an alcoholic family. Video is designed to teach young people better coping skills and to inform other children and adults of ways they can help. *Children of Alcoholics Foundation, Inc.*

**Steroids: Shortcut to Make-believe Muscles** *(1990, 35 mins., video only).* This video was designed for health education, and takes an in-depth look at steroids and why they should not be used by healthy people for non-medical reasons. Through interviews with a college athlete, a U.S. Navy doctor, and several coaches, the video discusses where steroids come from and cites the lack of quality control in their production. Underscores the many dangers steroids pose for men and women in athletics. Study Guide. *Sunburst Communications.*

**Teaching Healthy Choices: Strategies for Substance Use Prevention in Grades K-2** *(1990, 50 mins., video only).* This video was produced by Bank Street College of Education to train teachers, counselors, and administrators to implement Project Healthy Choices, a substance-use prevention program for children in grades K-2. It is divided into three parts: Self-assessment, Healthy Choices in Action, and Getting Started. Study Guide. *Select Media.*

**The Substance Abuse Series** *(1990, 15-20 mins. each, video only).* A series of six videos: About Alcohol, Young People and Alcohol, About Drinking and Driving, About Drug Abuse, Young People and Drug Abuse, and About Cocaine and Crack. The unique three-part format of each video captures on-the-street interviews, commentary by experts, and special animation. Study Guide. *Channing L. Bete Co., Inc.*

**Wasted: A True Story** *(1983, 24 mins., 16mm/video).* A dramatic case history demonstrates how substance abuse affects not only the user, but the whole family as well. Combining animation and candid interviews with a teenage brother and sister, this film is a powerful "from one kid to another" message that weighs the highs that the brother experienced against what he lost as a drug addict: self-respect, family trust, and friends who cared. *MTI Film and Video.*

**When Your Parent Drinks too Much** *(1987, 27 mins., 16 mm/video).* Most children of alcoholics feel isolated and alone; other feelings accompany the "disease of denial" such as anger, humiliation, and helplessness. In order to help children of drinking parents, this film portrays three different family situations and the ways in which children involved handle the disease. Study Guide. *MTI Film and Video.*

**Women, Drugs and Alcohol.** *(1980, 21 mins., 16mm/video).* Women's growing dependence on and addiction to legal drugs and alcohol is presented. Film examines doctor/patient relationship in the prescribing of drugs, early signs of abuse, alternatives for coping with stress and conflict, and the need for support systems when confronting the issue of drug or alcohol abuse. *MTI Film and Video.*

## Video/Film Distributors

**Channing L. Bete Co., Inc.** (800/628-7733)
200 State Rd., South Deerfield, MA 01373

**Children of Alcoholics Foundation, Inc.** (212/754-0656)
P.O. Box 4185 Grand Central Station
New York, NY 10163

**Guidance Associates** (914/666-4100)
P.O. Box 3000, Mount Kisco, NY 10549

**Media Projects, Inc.** (214/826-3863)
5215 Homer St., Dallas, TX 75206

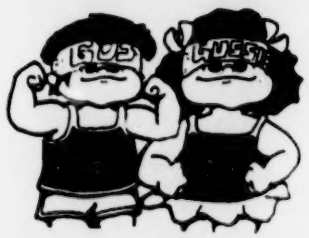
**MTI Film and Video** (800/621-2131)
108 Wilmot Rd., Deerfield, IL 60015

**Select Media** (212/431-8923)
74 Varick St., Third Floor, New York, NY 10013

**Sunburst Communications** (800/431-1934)
39 Washington Ave., P.O. Box 40
Pleasantville, NY 10570

*David L. Giveans is nationally known for his reviews of current films and videos focusing on a wide variety of parenting and related issues. He has coordinated a Video Theater for leading parenting and educational conferences including three national events for the Family Resource Coalition. David is also an author, lecturer, publisher, and consultant in early childhood education.*

## School-Based Programs & Curricula




### *Growing up Strong (GUS)*

The University of Oklahoma
Center for Child and Family Development
555 Constitution St., Room 221
Norman, OK 73037-0005 405/325-1446
Ann O'Bar, Associate Director

This curriculum is designed to develop strong mental health in preschool and elementary school children, tailored to their specific developmental levels and interests. GUS believes that the best way to prevent drug abuse, and a number of other problems that can develop in older children, is to enhance self-esteem and to help every child develop positive habits, attitudes, and life skills as early as possible. GUS is used as an integral part of a total early childhood curriculum; its features include classroom activities, teacher information, family involvement, GUS and GUSSIE dolls and puppets, resources, and information on evaluation, screening, and assessment. Exercises, role-playing, and a variety of discussion topics are handled in culturally, ethnically, and racially sensitive ways. GUS promotes a productive teacher-child-family relationship through meetings, open house get-togethers, and particularly through a series of activity and information sheets sent home to parents weekly. Spanish Bilingual * and Native American supplements of the GUS program are also available.

### *It's Elementary*

National Association for Children of Alcoholics
(NACoA) 31706 Coast Highway, #201
South Laguna, CA 92677 714/499-3889

It is estimated that there are 28.6 million children in the U.S. who are affected by parental alcoholism; of these 6.6 million are under the age of 18. Because the home life of these children affects their ability to learn and perform academically and socially in the school environment, NACoA has developed the National Elementary School Project for Children of Alcoholics titled *It's Elementary.* OSAP and the U.S. Department of Education have cooperated with NACoA in sponsoring this project which assists school staff. Components of *It's Elementary* include: Marvel Comics posters; a Spiderman comic book for children (produced in cooperation with the National Committee for the Prevention of Child Abuse); a guidebook, *It's Elementary: Meeting the Needs of High-Risk Youth in the School Setting*, designed for teachers, administrators, and counselors; and a school/community-based training film and training programs. NACoA operates a clearinghouse, produces a quarterly newsletter, and sponsors regional and national conferences annually.

### *Star Parents: Skills for Effective Parenting* IRI/Skylight Publishing, Inc.

200 E. Wood Street, Suite 250
Palatine, IL 60067 1/800-922-4474

The two-part Star Parents program introduces a basis for strong teacher-student-parent teams. Its first step is a Training Manual (K-14) for a school or district trainer to use with parents. The book's information and ideas help students become responsible decision-makers and thinkers who can sort out problems, analyze possible solutions, and build a healthy, substance-free lifestyle. For parents and teachers who have first completed the training program, the Parent Booklet offers an active learning approach for practicing and using their skills and strategies at home. In addition, the Star Program offers training and materials for three student age groups: Early Stars, focused on helping students say yes to foods and activities that are healthy; Team Stars, helping students work together cooperatively at stages when peer pressure is at a peak; and Star Choices, providing older students with facts about substance use and abuse and practice in dealing with tough situations that involve alcohol and other drugs.

### *Common Sense: Strategies for Raising Alcohol- and Drug-Free Children* 1/800-225-5483

A partnership of the National PTA and the GTE Corporation has developed a prevention program that spotlights specific ways parents can minimize the risk that their children will become involved with alcohol and drugs. Designed for use by PTAs and like groups to educate parents of children in grades 3–6, the program focuses on three areas: building strong bonds to family and school; establishing rights, rules, and limits; and providing children with good parental role models. The program kit contains instructions for organizing and conducting four interactive meetings, and strategies for leaders to use in getting parents and others involved in drug prevention. PTAs can receive one kit free by calling 1/800-225-5483; civic, community, or other parent teacher organizations can obtain a kit for $44. Selected materials from the kits have been translated into Spanish. *

### *Project STAR*

9300 Ward Parkway, P.O. Box 8480
Kansas City, MO 64114 816/966-3601
Dr. Calvin C. Cormack, Executive Director

This alcohol and other drug resistance program, funded and administered by the Ewing Marion Kauffman Foundation, is a 13-lesson curriculum taught by selected teachers in all metropolitan Kansas City public and private schools. STAR strives to teach students to recognize the factors that influence them to use alcohol and other drugs, and to help them develop the skills needed to resist those influences. Project STAR is also being taught in more than 50 percent of the middle schools throughout Missouri and Kansas, in several Colorado schools, and is being piloted in Washington, DC. Project STAR believes prevention strategies need to go beyond school-based curricula and aids local, state, and national efforts to influence social policy change; offers technical assistance to developing programs; and promotes healthy communities through its STAR Connections and STAR Baseline programs.

## Publications

### *Families InTouch*

The Parents InTouch Project
343 Dodge Avenue Evanston, IL 60202
708/864-5660 Mr. Lewis Koch

Written by an award-winning family author, scriptwriter, and columnist—Joanne Barbara Koch—this 6-book series helps *parents* understand and adapt information on alcohol, drugs, sex, and AIDS to their own value system and their own children. There are three age groups involved: 5–7, 8–10, and 11–15. Each group has two books—one for parents to read themselves, and one for parents to read with their children. The format is lively, interactive, and the graphics warmly reflect a variety of ethnic families. FIT reinforces children's self-esteem and teaches them to distinguish between healthy and unhealthy choices in the problematic issues of avoiding alcohol and other drug use, premature and inappropriate sexual activity, and AIDS. For parents who experience difficulty discussing these subjects with their youngsters, the books help them "rehearse" beforehand. Initially launched by DASA throughout Illinois (see page 17), more than a million Families InTouch books ($10 for a set of two) are in use across the country (a Spanish * language version is also available). New on the market, also modestly priced, is a school-based package of Instructor's Guides and Student Journals for each of the age groups. Discounted bulk quantities are available. The program's certification by OSAP makes the books eligible for purchase using federal Drug Free School funds.

### *Fatal Attraction: The Selling of Addiction*

Center for Media and Values
1962 Shenandoah Street
Los Angeles, CA 90034 213/559-2944

"We cannot make progress in reducing our society's drug problem until young people understand how the addiction merchants are using the media to manipulate them." That's the message of articles and action ideas in the spring/summer 1991 issue of Media&Values magazine that makes the connection between media messages about alcohol and cigarettes and the addictive lifestyle they sell. One article points out the marketing ploys used to attract ethnic and minority groups, and another helps teachers and kids analyze the subtle techniques of advertising copywriters. This issue is another in the Center's efforts to teach media literacy. The next step, available in early 1992, is their new *Selling Addiction: A Workshop Kit on Tobacco and Alcohol Advertising*, designed as a curriculum resource for schools, churches, youth groups, and community centers, with a videotape, lesson plans, handouts, evaluation forms, and further resources.

*Continued*

## Culturally Specific Resources

### Office of Minority Health Resource Center

U.S. Department of Health & Human Services
Public Health Service, P.O. Box 37337
Washington, DC 20013-7337 1/800-444-6472

OMHRC maintains information on health-related resources—available at the federal, state, and local levels—that target Asians and Pacific Islanders, Blacks, Hispanics/Latinos, and Native Americans. Information Specialists handle calls from consumers and health professionals, referring requests to appropriate organizations, locating relevant materials, and identifying sources of technical assistance. Their database includes sources of free or low-cost services, and a network of professionals who provide expert technical assistance to minority community-based organizations, volunteer groups, and individuals. A series of fact sheets entitled "Closing the Gap" shows the health disparity between minorities and non-minorities, describing the extent to which specific groups are affected, avenues of prevention, and sources of additional information.

### COSSMHO: The National Coalition of Hispanic Health and Human Services Organization

1501 16th Street NW, Washington, DC 20036
Gloria Martinez, Program Ass't. 202/797-4343

COSSMHO has developed a package of three bilingual booklets to be used as a classroom or home supplement to a drug prevention program: *Dile que no! Just say no!* (for children); and *Ayudando a sus alumnos a decirle que no, Helping your students say no* (for teachers and for parents). Upbeat, visually appealing, educational, and motivating through celebrity messages from Linda Ronstadt, Edward James Olmos, and Gloria Estefan, these booklets contain games, music, puzzles, etc. geared to helping youngsters with a Stay smart! Don't start! approach. Individual and bulk copies available.

### Institute on Black Chemical Abuse, Inc.

2616 Nicollet Avenue
Minneapolis, MN 55408 612/871-7878

IBCA addresses alcohol and drug abuse in the black community, providing direct services locally and training and consultation nationally. Their special expertise in the cultural aspects of chemical dependency is used in developing counseling strategies, assessing community service needs, and prevention planning. Individual and family counseling, home-based services, outpatient treatment, aftercare, and a family violence program are among IBCA's services. A variety of technical assistance services are available; a Resource Center collects, disseminates, and produces publications and information on black chemical abuse; and an active Volunteer and Intern Program attracts students and professionals for extended training, and options for community involvement.

## Government-Related Information Sources

### NCADI, the National Clearinghouse for Alcohol and Drug Information

P.O. Box 2345 Rockville, MD 20852
1/800-729-6686 or 1/800-SAY-NO-TO (Drugs)

NCADI is the national center for citizen information and resources on every facet of alcohol and other drug abuse. A phone call connects you with a specialist who can do a database search; mail grant announcements and application kits; take a subscription for *Prevention Pipeline*, the bi-monthly newsletter about prevention research, resources, and activities; and inform you about a free audiovisual loan service. A Publication Catalog, printed twice yearly, lists free posters, fact sheets on individual drugs, booklets, and statistics; data for prevention program planners, health care providers, and educators; and materials on treatment and rehabilitation, racial and ethnic minorities, the elderly, women, youth, AIDS, workplace programs, etc. In addition, the Catalog publishes a list of the state RADAR (Regional Alcohol and Drug Awareness Resource) Network Centers which consist of state clearinghouses, specialized information centers of national organizations, and the Department of Education Regional Training Centers. NCADI talks to 17,000 callers each month. In response to questions that recur frequently, they have developed a new series of Resource Guides for specific groups that include high school students, preschoolers, African Americans, Hispanics/Latinos, Pregnant and Postpartum Women; topics include Rural Health Issues, Prevention Curricula, Community Action Fundraising, et al. NIDA (National Institute on Drug Abuse) materials are also distributed by NCADI.

### OSAP: The Office for Substance Abuse Prevention

U.S. Department of Health & Human Services
5600 Fishers Lane, Rockwell Bldg.,
Rockwell, MD 20857 301/443-0369

- Promotes and distributes prevention materials (posters; brochures; resource kits for parents, youth, and teachers; directories; program descriptions) throughout the country.
- Develops materials and disseminates information from its database (at NCADI) on prevention, intervention, and treatment for a variety of audiences.
- Provides continuing education training for professionals in health and health allied fields, and multicultural training workshops for professionals, parents, and youth.
- Supports community-based prevention programs through grant programs and on-site consultation.
- Supports the National Clearinghouse for Alcohol and Drug Information (NCADI) and the Regional Alcohol and Drug Awareness Resource (RADAR) Network (see NCADI).
- Develops partnerships with a variety of local, state, and national organizations to ensure a comprehensive approach to addressing alcohol and other drug problems.
- Sponsors a multi-year, public education program, "Be Smart! Stay Smart! Don't Start!" targeted to preadolescent and teenage audiences.

### The Federal Drug, Alcohol, and Crime Clearinghouse Network

As of August 15, 1991, anyone in the U.S. can call 1/800-788-2800 and immediately access any of seven federal clearinghouses and information centers focusing on alcohol and other drugs. The Department of Health and Human Services, the Department of Justice, the Department of Housing and Urban Development, and the Department of Education have established this network which serves as a single point of entry for all federal alcohol and drug clearinghouses addressing the following topic areas: alcohol and other drugs information and prevention; drugs and crime; drug abuse treatment; drug-free workplace programs; alcohol and drug abuse prevention in public assisted housing; AIDS, drug abuse, and prevention; and criminal justice issues on the national and international level.

## Parent Education Programs

### *Discovering Normal: A Parenting Program for Adult Children of Alcoholics and their Partners*

Children of Alcoholics Foundation, Inc.
P.O. Box 4185, Grand Central Station
New York, NY 10163 212/754-0656
Irene Bush, Director of Parenting Project

Having been affected by familial alcoholism, adult children of alcoholics often need help in learning how to raise their own children and to become effective, confident parents. The new curriculum from COAF, *Discovering Normal*, is designed to strengthen such families. Material is presented in a small group format to be facilitated by one or two group leaders, the course to be presented over 6 or 10 weeks, each segment lasting 1½–2½ hours. *Discovering Normal* has been tailored for ACOAs who may not have had parental role models, and who, as a result, may be unsure, overly rigid, or punitive. The program helps these parents understand that their children develop within a range of normal, and there is no way to predict a particular child's physical or emotional development. The needs of both parent and child must be met and positive communication established to ensure a balanced family life. The program can be put to use in family and child serving agencies, alcoholism treatment agencies, and parent support centers.

### *Preparing for the Drug Free Years*

Developmental Research and Programs, Inc.
130 Nickerson, Suite 107
Seattle, WA 98109 1/800-736-2630

This program is a risk-focused workshop for parents of children in grades 4–7. At the same time it helps parents understand the widespread dangers of teen drug abuse, it also empowers parents to develop an action plan to keep the family drug-free. Based on the extensive research of Drs. David Hawkins and Richard Catalano at the University of

Washington, *Preparing for the Drug Free Years* is a prevention program combining live presentations by local workshop leaders with video instruction, skill building, and practical demonstrations in 5 2-hour sessions:

- Getting Started: How to Prevent Drug Abuse in Your Family
- Setting Guidelines: Developing a Family Position on Drugs
- Avoiding Trouble: How to Say No to Drugs
- Managing Conflict: How to Express and Control Anger
- Including Everyone: Strengthening Family Bonds

A 142-page *Family Activity Book* gives parents a written record of the program content, worksheets for important tasks, agendas for family meetings, and exercises to extend the program as an integral part of family life. *The Leaders' Guide* is for educators, medical, social, and human service workers, and school and civic group leaders who will then conduct parent workshops. *A Workshop Leaders Guide* is used in conjunction with the programs, videotapes, and *Drug Free Years Curriculum Kit*. *The Drug Free Tool Kit* provides marketing materials, incentives, and a planning guide for promoting workshops.

### *Families for Prevention*

Experience Education
4944 S. 114th St. Omaha, NB 68137
1/800-477-4236
William Horner, President

The major component of *Families for Prevention* is a 40-minute videotape for parents of 3rd graders to view in their own homes (audiotapes are also available for those who need them). The tape combines a 20-question test—to be scored by the parents—that helps families assess their children's risk for drug use, with tips for parents on how to deal with children more effectively to avoid alcohol and other chemical dependency in later life. For those families who find their risk scores high, an accompanying pamphlet lists local and national help numbers to phone for information and resources. The tape is narrated by celebrity dancer, Ben Vereen, and is interspersed with advice and research information. A school package consists of 30 videos, 8 audiotapes, 5 classroom posters, 5 program guides, and pamphlets for parents. *Families for Prevention* is also available in Spanish.*

### *Talking with Your Kids about Alcohol* (TWYKAA)

Prevention Research Institute
629 N. Broadway, Suite 210
Lexington, KY 40503 606/254-9489
Terry O'Bryan, Executive Director

Parents worry about *all* drugs, but more and more parents are learning that the drug most often used by teens is alcohol. Studies show that kids have seen 100,000 beer commercials before they reach legal drinking age, and the success of their parties is often measured by how much alcohol is consumed. The leading cause of death among teens is alcohol-related motor vehicle accidents. But even talking about alcohol makes many parents anxious, so TWYKAA teaches them what to say and how to say it. A nationally recognized and evaluated prevention program, TWYKAA uses parents as the primary prevention force in their kids' lives, and believes parents have the right and the responsibility to learn the facts about alcohol and communicate them to their children. The TWYKAA program is for the parents of any age child who is not chemically dependent. The goals of the course are to increase abstinence, delay age of onset, and decrease use. The program is taught in 4 2½-hour sessions; more than 1400 instructors have been trained in the 4-day workshops to teach groups of 15–20 parents in their own community or school district. Both didactic and experiential, the course empowers parents to set clear expectations and consequences about drinking. TWYSAA, Talking With Your Students About Alcohol, is a school-based version of the program.

## *National Programs that Organize and Train Parents and/or Children in Prevention Strategies*

### National Families in Action

2296 Henderson Mill Road, Suite 204
Atlanta, GA 30345 404/934-6364
Sue Rusche, Executive Director

NFIA's thrust is in arming ordinary citizens with accurate information about the harmful effects of drug abuse, and empowering them to organize and take action to bring about positive change for their families and communities. Central to all NFIA's activities is its National Drug Information Center, currently housing some 500,000 documents on drug abuse. The staff provides written materials, phone consultation, referrals for treatment, public speakers, and public policy statements on issues around drug abuse and prevention. The Center also serves as a RADAR site, providing support, guidance, and linkage for neighborhood groups. NFIA publications include a step-by-step guidebook, *How to Form a Families in Action Group for Your Community*, and *Crack Update*, a brochure outlining the effects of crack/cocaine abuse. *Drug Abuse Update for Kids* is being developed as are *Updates* on 25 different drugs of abuse. NFIA's drug education curricula, *You Have the Right to Know*, is designed to help families in public housing organize drug prevention groups. Under a grant from OSAP, the first one in its series, *You Have the Right to Know: Cocaine*, is now available.

### National Federation of Parents (NFP) for Drug Free Youth

9551 Big Bend St. Louis, MO 63122 314/968-1322
Phyllis Dettman, Executive Director

NFP, now 11 years old, aids in the formation and support of local parent and youth groups, and provides training to secondary school students. Each year, through their REACH America and LIFERS programs, 10,000 14–19-year olds learn about chemical dependency, how families are affected by the drug culture, drugs and crime, and the dangers of drug abuse. A 2-day REACH America training seminar helps students acquire leadership skills and prepares them to present lectures, demonstrations, and skits to younger students. LIFERS, the newest NFP program, works with 7th and 8th graders through a process of refusal skills, problem solving, drug fact and education, and peer support. The Parents Involved program trains parents for leadership roles in their communities. As members of task forces, advisory committees, and parent organizations, they can participate as learners and/or achieve trainer-of-trainers competency. NFP's National Red Ribbon Campaign is a once-a-year effort to create awareness concerning alcohol and other drugs and mobilizes community coalitions to implement prevention strategies.

### PRIDE (Parent Resource Institute for Drug Education)

50 Hurt Plaza, Suite 210
Atlanta, GA 30303 404/577-4500

PRIDE is devoted to drug abuse prevention through education. Their programs reach parents and youth at home, in school, and at the workplace, and advocate a community approach to solving problems:

- The PRIDE Questionnaire, geared to students in grades 4–6, 6–12, and college, is used to determine the scope of a community's adolescent drug use, and to plan prevention activities and education.
- The Parent to Parent Program is a video-based, 8-module training workshop taught in small, interactive groups. The program uses trained local facilitators who tailor the workshops to specific community needs, offers a Leaders Guide, provides Student Kits, and publishes a promotional newsletter.
- PRIDE sponsors an annual World Drug Conference (1992 in Houston, Texas, April 30–May 2), spotlighting innovative and successful drug abuse prevention programs.
- America's PRIDE is a musical performance that examines the causes and prevention of drug use by children and youth. Students aged 15–18 years learn singing, dancing, drama, and public speaking from 18–19 year old trainers who prepare them to help other young people be drug-free.

### Project CODE (Collaboration on Drug Education)

Community Connections, Inc.
3516 Tony Drive San Diego, CA 92122
Karen Knab, Director 619/453-2361

Project CODE trains teams of parents, school staff, and community representatives to become facilitators who in turn train parents in drug prevention techniques, communication skills, and positive parenting strategies. After 60 hours of training (46 hours in the classroom, 14 hours visiting self-help groups and community resources), the teams deliver a 10-hour Substance Abuse Prevention Workshop for families of school-age children at a school site or community agency where they set up referral systems, establish family support groups, and answer queries about drug prevention and intervention. CODE was developed to meet the needs of culturally diverse communities, to include families in an active role, and to bring together the influence of home, school, community, business, and religious institutions. The program is already available in Spanish* with Asian translations due shortly.

FAMILY RESOURCE COALITION

## FRC Fourth National Conference

### Come ready to network and learn. Leave ready for Monday morning.

When you commit your valuable time and hard-to-come-by resources to a conference, you want to leave *inspired*. You want your mind to *race* with what we call "Monday morning ideas"—all those things you want to try as soon as you get back to work.

However you work with families—in a family support program or school; in religious or health care setting; as a therapist, policymaker, or academician—the Family Resource Coalition conference is the only national gathering which brings together such a wide range of top-notch professionals with a common interest in family support.

Whether you are an experienced family support veteran or a newcomer who wants to learn from the best, you'll find colleagues who are wrestling with some of the same issues and challenges you face. You'll hear from the leading thinkers in the field and you'll meet people with a track record in making programs work.

Here at the Coalition, we're doing everything we can to make sure you leave the conference *full* of Monday morning ideas. Why not do everything *you* can to make sure you're there?

Register by March 1st for a discount of nearly 20%. See your conference brochure for details.

The Family Resource Coalition
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Suite 1520
Chicago, IL 60604

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**EDITOR'S NOTE:** Looking over my eight years as editor of the *FRC Report* is a wonderful, satisfying experience. I have been personally enriched, as have all of you, by the remarkable people who wrote about what they knew—on many levels, on countless subjects—and by the talented design and print team who made the words come alive. Together we moved the *Report* from a fledgling newsletter to a mature publication with a national reputation. It's been an exciting time! Kathy Goetz, the Director of Publications, takes over as editor with the next *Report*. —J.S.

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